

00-17522

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		MICHAEL M. ABRAMS		Sept. 9, 1986		6:50a.m.	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		April 23, 1919		67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
New York		U.S.A.				Montgomery County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		General Const.		Building	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Florida		Palm Beach		Delray Beach		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
William		Anna		Yes		076-12-2483	
		Lobell		Chevy Chase, Md. 20815		Marian Abrams; Wife; 4720 Chevy Chase Drive;	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>dilated cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure & ventricular tachycardia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>8-14-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Randolph S. Pallas, M.D.		M.D.				9/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE			
RANDOLPH PALLAS, M.D.		3800 Reservoir Road; Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9/11/86		King David Mem. Gardens		Falls Church; Fairfax; Va.	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
Danzansky-Goldberg Memorial Chpl.		SEP 10 1986					
1170 Rockville Pike; Rockville, Md. 20852							

MEDICAL CERTIFICATION

00-15255

00-15255

00-18418

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 6 2 6 2 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOE			2a. DATE OF DEATH MONTH DAY YEAR 8 28 86			2b. HOUR 10:55 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 2 31		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19507 Kildonan Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Hardware	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19507 Kildonan Drive 20879	
14. FATHER'S NAME FIRST MIDDLE LAST Marshall Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Massey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946-49		17. INFORMANT ADDRESS Mrs. Jane Adams - Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma -</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>primary site not determined</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-18-86</u> to <u>8-28-86</u> , that (I) (we) lost saw the deceased alive on <u>8-18-86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Donald R Bucy</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9-2-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Donald L Bucy</u>						22e. ADDRESS <u>809 Vears Mill Rd Rockville</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal.			23b. DATE 8-28-86		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		24a. DATE REC'D. BY REGISTRAR SEP 10 1986	
25. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>									

BP

81481-00

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Handwritten text, possibly a name or title.



00-18941

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 0 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ghevont M. Aghajanian			2a. DATE OF DEATH MONTH DAY YEAR 9-19-86			2b. HOUR 1910 M						
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 07 15 1891		6. AGE LAST BIRTHDAY 95 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Armenia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.						
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Importer		12b. KIND OF BUSINESS OR INDUSTRY Self Employed				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 8200 Wisconsin Avenue/20814		
14. FATHER'S NAME FIRST MIDDLE LAST Minas Aghajanian			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Nalbandian									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 085-28-1286A		17. INFORMANT Lenore M. Kurkjian			ADDRESS 9213 Seven Locks Road Bethesda, Maryland 20817				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic diarrhea, malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>gastrointestinal bleeding</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9/17/1986</u> to <u>9/19/1986</u> , that (I) (we) last saw the deceased alive on <u>9/19/1986</u> , and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Mary H. Fang, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary H. Fang, M.D.					22e. ADDRESS 11004 Roundtable Ct. Rockville, Md. 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS 7557 Wisconsin Avenue Bethesda, Maryland 20814					25a. DATE REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 23 1986							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-00

00-19621

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET E. Ahlers			2a. DATE OF DEATH MONTH DAY YEAR 9 20 86			2b. HOUR 9 20 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 16, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY at home	

13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4258 Nicholas Ave. 21206		
FATHER'S NAME FIRST MIDDLE LAST Isaac Lorenza A. Stephens						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Pearl Meads								
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			14b. SOCIAL SECURITY NO. 218-50-5580			17. INFORMANT Dr. Richard Reichard			ADDRESS 9701 Veirs Drive Rockville, Md.					

18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Heart Late Obstruction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 503 A 00 P	
DUE TO, OR AS A CONSEQUENCE OF: (b) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from May 82 , to Sept 21 , 19 84 , that (I) (we) lost Sept 20 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Thomas E. Doolley, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept 21, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Doolley, MD		22e. ADDRESS 17904 GEORGIA AVENUE CENNEY, MARYLAND 20822					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
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24. FUNERAL DIRECTOR NAME ADDRESS Hysong Company, 1300 N St. N.W. Wash. D.C.		25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE John T. Rindler	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the funeral director 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

18851-10

18851-10

18851-10

18851-10

00-17923

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 6 2 6 2 1 1	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) AKHIL AHUJA										20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 10 1986	
3. SEX M		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 10 18 85		6. AGE (IN YEARS) LAST BIRTHDAY YRS 10 22		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		21. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 10 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH ROCKVILLE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE MD				13b. CITY OR TOWN MONTGOMERY GAITHERSBURG				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20760 19574 RIDGE HEIGHTS DR	
14. FATHER'S NAME FIRST MIDDLE LAST Shaski Ahuja				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rita Bajaj							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS Shaski Ahuja (father) Same as 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 9104 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00 9 10 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) PLAYING IN BATHTUB			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19574 RIDGE HEIGHTS DR GAITHERSBURG MONT MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Francis C. Myle				TITLE (SPECIFY) DEPT				MEDICAL EXAMINER		DATE SIGNED 9/10/86	
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MYLE				ADDRESS 8200 Wisconsin Ave Bethesda MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Sept. 11, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Sindland Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE John Davidson			

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

00-15253

NOV 19 1953

MINIATURE



00-17132

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26212

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOUISA C. ALBERTI			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1, 1986		2b. HOUR M 1:05 P
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 31, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 1 05 P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16500 Jilrick Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Carmody		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Lynch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 263-41-4890		17. INFORMANT ADDRESS Louis A. Alberti, Jr. Son Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Cell Carcinoma; Arterio-sclerotic					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, FURNISH MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN 11a OR 11b OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from 8/19 19 83 to Present 19 86 and that in my (our) opinion death occurred on the date and hour and from the cause stated.					
22b. SIGNATURE Douglas R. Shumaker		DEGREE M.D.		22c. DATE SIGNED Sept. 2, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas R. Shumaker, M.D.		22e. ADDRESS 615 W. Montgomery Ave. Rockville, MD 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sep. 4, 1986	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	25a. DATE REC'D. BY REGISTRAR SEP 5 1986	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25b. REGISTRAR'S SIGNATURE John Davidson		25c. REGISTRAR'S NAME John Davidson	
500 University Blvd., W. Silver Spring, Md.					

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1570 Little Street

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1550 Little Street 20853

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Charlotte

Canada

E.

Robert

253-1-4407 Louis A. Herbert Jr. 208 same as 12

116

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Washington

Washington

200-1-1014 Washington National

Francis J. Collins Jr.

200 Independence Blvd. N. 208 same as 12

Clinton

00-18449

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 2 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine Alterescu			2a. DATE OF DEATH MONTH DAY YEAR September 17, 1986			2b. HOUR 7:45 A		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR April 1, 1917		
6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			7. CITIZEN OF WHAT COUNTRY? USA			8. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3943 Wendy Lane		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Artist			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST MIDDLE LAST Martin Dragon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Slota			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
17. SOCIAL SECURITY NO. 075-10-4636			18. INFORMANT Sidney Alterescu			19. ADDRESS Husband Same as 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/9 , 19 86 , to 9/17 , 19 86 , that (I) (we) last saw the deceased alive on 9/16 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard P. Delaney				DEGREE MD.		22c. DATE SIGNED 9/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.				22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sep. 17, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE RECEIVED BY REGISTRAR SEP 19 1986			
25b. ADDRESS 500 University Blvd., W. Silver Spring, Md.							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there may be injury, or other traumatic event, the medical examiner will be notified.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true when any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26214

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GERALD A Alvarez			2a. DATE OF DEATH MONTH 9 DAY 10 YEAR 86			2b. HOUR 805 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 2 YEAR 91		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spain		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank Clerk Ret.		12b. KIND OF BUSINESS OR INDUSTRY Bank		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9501 Milstead Dr. 20817	
14. FATHER'S NAME FIRST Santos MIDDLE LAST Alvarez			15. MOTHER'S MAIDEN NAME FIRST Regina MIDDLE LAST Del Puerto							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (son-in-law) ADDRESS 20817 Thomas Deely- 9501 Milstead Drive, Beth. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediately 2 yr										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: pleural effusion, bronchitis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 7/10 19 86 to 9/10 19 86 , that (I) (we) last saw the deceased alive on 7/10 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Lewis N. Cahill					DEGREE MD			22c. DATE SIGNED 9/10/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS N. CAHILL MD					22e. ADDRESS 5414 WOODBARK LN, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-12-1986		23c. NAME OF CEMETERY OR CREMATORY Mount St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flushing Queen N.Y.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home					11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 13 1986			
25b. REGISTRAR'S SIGNATURE										

BP

00-1736

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 1 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HOMER L. ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 9-22-86			2b. HOUR 1:10 AM			
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 4 19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pourer		12b. KIND OF BUSINESS OR INDUSTRY Bronze Co.	
13a. STATE Pennsylvania		13b. COUNTY Lawrence		13c. CITY OR TOWN New Castle		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 615 West North Street / 16101	
14. FATHER'S NAME FIRST MIDDLE LAST Wallace Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Marks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 171-12-3017		17. INFORMANT Dorothy Webber, 11700 Old Columbia Pike Silver Spring, MD 20904			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Prostate Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 hrs. 3 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PARAPLEGIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 15 June 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
21g. I certify that (a) this hospital or other institution where deceased from 15 June 1986 to 22 Sept 1986 (we) lost saw the body of deceased on 25 Sept 1986 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If certified did not, saw the body after death)									
22a. SIGNATURE Thomas A. Bensinger MD						DEGREE MD		22c. DATE SIGNED 9/22/86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger						22e. ADDRESS 7526 Greenway Ctr Drive Greenbelt MD 20770			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-27-86		23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lawrence County, Pennsylvania		
24. FUNERAL DIRECTOR Richard Rapp, Inc. NAME ADDRESS 1804 T Street, NW, Washington, DC 20009						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

0-17906

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Injury," an other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 2 1 6	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Ruth Herron Anderson						2a. DATE OF DEATH MONTH DAY YEAR September 10, 1986			2b. HOUR am 1:15 M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 25, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		7b. HOUR am 1:15 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b. KIND OF BUSINESS OR INDUSTRY D.C. Government			
13a. STATE MD.				13b. COUNTY Washington, DC		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1515 32nd Street N.W. 20007	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph C. Herron						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Not Available					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Friend) ADDRESS# Atty. Robert W. McChesney, Ave., Washington, DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Collapse										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Hiatus Hernia & Introthoracic Stomach										30 days 20 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Brain Syndrome Secondary to Cerebral Arteriosclerosis											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) did not attended the deceased from March 16 , 19 86 , to Sept. 10 , 19 86 , that (I) do lost saw the deceased alive on August 23 , 19 86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death.											
22b. SIGNATURE Joseph Neill Kennedy, M.D.						22c. ADDRESS 1145 19th St NW, Washington, D.C.		22d. DATE SIGNED September 10, 1986			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE September 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Ellyn, Illinois			
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes P.A. 7557 Wisconsin Avenue, Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE <i>Davidson-Rodriguez</i>			

[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side. Some faint vertical lines and horizontal strokes are visible.]

0-18812

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Lucia</i> MIDDLE <i>-</i> LAST <i>Anselmo</i>			2a. DATE OF DEATH MONTH <i>9</i> DAY <i>20</i> YEAR <i>86</i>			2b. HOUR <i>12 34 PM</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH <i>7</i> DAY <i>15</i> YEAR <i>94</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Sicily</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Montgomery-Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>#6 Barn Ridge Court</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6 Barn Ridge CT / 20906</i>					
14. FATHER'S NAME FIRST <i>Mariano</i> MIDDLE <i>-</i> LAST <i>LiCausi</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Rosario</i> MIDDLE <i>-</i> LAST <i>LoPinto</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-321308</i>		17. INFORMANT ADDRESS <i>Salvador Anselmo (Son) Same as #13E</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary rupture</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CAD, FAT</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9/20/86</i> <i>1900</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Reflex myofascitis, osteoarthritis</i>							
19a. DATE OF OPERATION <i>3/19/85</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>@cataract operation</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>-</i> <i>-</i> <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>-</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>6 BARN RIDGE CT Silver Spring Montgomery MD</i>		21f. LOCATION CITY OR TOWN COUNTY STATE <i>Montgomery MD</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/10</i> , 19 <i>86</i> , to <i>9/20</i> , 19 <i>86</i> , that (I) (we) saw the deceased alive on <i>9/19</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur Santangelo</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>9/20/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur Santangelo</i>				22e. ADDRESS <i>1814 Prince Philip Dr, Olney MD 20852</i>			
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>9/24/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>S.S. Mont. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Rinaldo</i> ADDRESS <i>11800 New Hamp. Ave. S.S. Md</i>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John T. ...</i>	

MEDICAL CERTIFICATION

SEP 22 1986



00-18466

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ellen G. Archer			2a DATE OF DEATH MONTH DAY YEAR September 17, 1986			2b HOUR 7:50a M				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR March 24, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10201 Grosvenor Place				12a USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) Biochemist		12b KIND OF BUSINESS OR INDUSTRY N.I.H.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland					13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William Clinton Archer					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera Crow					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO. 193 26 2961		17 INFORMANT Brother ADDRESS RD#1 Prosperity, W. Leland Archer Pennsylvania 15329					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Months 4 Years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 81, to September 17, 1986, that (I) (we) last saw the deceased alive on September 8, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jeremy V. Cooke M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Sept 17, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke					22e. ADDRESS 10400 Connecticut Ave. Kensington, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Prosperity Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington County, PA			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P.A., 7557 Wisconsin Ave., Bethesda, MD					25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

SEP 19 1986

20481-0

(1)

20481-0

00-19372

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical certificate should be filed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 6 2 1 9 4:43 am	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) TONY F. ARNONE					2a. DATE OF DEATH MONTH DAY YEAR 9 21 86					2b. HOUR 4:44 A.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 14 21			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superior Upholstery			12b. KIND OF BUSINESS OR INDUSTRY Senate	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1908 August Drive 20902				
14. FATHER'S NAME FIRST MIDDLE LAST Salvatore Arnone					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Arnone						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II					16b. SOCIAL SECURITY NO. 212-01-7500		17. INFORMANT ADDRESS Delphina R. Arnone Wife Same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension DUE TO, OR AS A CONSEQUENCE OF (c) Multi Organ Failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Lymphocytic leukemia (b) Sepsis (c) Renal Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION 9/20				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 8/15 19 86				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 15 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO WHILE <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11141 Georges Ave - Ste 104 Wheaton, MD 20902							
22a. I certify that (I) (this hospital) attended the deceased from 9/20 19 86 , and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.											
22b. SIGNATURE Ravi Passa				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/21/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ravi Passa M.D.				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sep. 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR SEP 25 1986				25b. REGISTRAR'S SIGNATURE			
500 University Blvd., W. Silver Spring, Md.											

00-17409

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) VIRGIL T BAILEY			2a. DATE OF DEATH MONTH DAY YEAR 9/3/86		2b. HOUR 11:35 AM
3. SEX Male M	4. RACE White W	5. DATE OF BIRTH MONTH DAY YEAR May 13, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Artist		12b. KIND OF BUSINESS OR INDUSTRY Art
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. STREET ADDRESS / ZIP CODE 4700 Western Ave. 20816	
14. FATHER'S NAME FIRST MIDDLE LAST Virgil Bailey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hanna Sparks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2 186-16-2328	17. INFORMANT ADDRESS Mrs. Mercedes Bailey same as item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) adenocarcinoma of the lungs with bone metastases about 6 months DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) —	21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —			
22a. I certify that (I) (this hospital) attended the deceased from August 1st 1986 to September 1st 1986 , that (I) (we) lost saw the deceased alive on September 2nd 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE JA Quipros MD		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATES SIGNED September 3rd 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JA Quipros MD		22e. ADDRESS 4343 Montgomery AV Bethesda MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-4-86	23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Virginia
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, 5130 W. N.W., Wash., D.C.			25a. DATE REC'D. BY REGISTRAR SEP 9 1986		
			25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

BP



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00-19029

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it is to be forwarded directly to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

Item # 5 & 15, Film G 620, 10.30.86 ra									
STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WINIFRED S. BARBER					2a. DATE OF DEATH MONTH DAY YEAR September 22, 1986			2b. HOUR 5:30 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH September 10, 1908 October 9, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3104 Verona Court, Silver Spring, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3104 Verona Court, S.S.Md. 20906.		
14. FATHER'S NAME FIRST MIDDLE LAST Morgan Stevens					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Medgley Miggley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS 11801 Eden Road, Gary B. Marshall, Grandson, S.S.Md. 20904.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from January 1, 1986, to after 1986, that (1) (we) last saw the deceased alive on Sept 8, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Michael R. Dobridge				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Sept. 22, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL R. DOBRIDGE, M.D.				22e. ADDRESS 13975 Connecticut Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G.Cty., Maryland			
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO., 8655 Georgia Ave., S.S.Md. 20910						25a. D. CHAMBERS, D. REG. NO. 125b. REGISTRAR'S SIGNATURE SEP 23 1986			

00-10052



RECEIVED

MD 6 2 22
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last BABY BOY BARRICK			2a. DATE OF DEATH Month Day Year Aug 14 86			2b. HOUR 10 A M								
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug 14, 1986		6. AGE (in years last birthday) YRS. MONTHS DAYS 0 0 0		IF UNDER 1 YEAR MONTHS DAYS 0 0 0		IF UNDER 24 HRS. HOURS MIN 00 00				
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.								
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE			12b. KIND OF BUSINESS OR INDUSTRY NONE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY HOVARD			13c. CITY OR TOWN ELKRIDGE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6306 Ducketts Lane		
14. FATHER'S NAME First Middle Last Dann Barrick			15. MOTHER'S MAIDEN NAME First Middle Last Hwa (Unk)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO						16b. SOCIAL SECURITY NO. N/A		
17. INFORMANT Dann Barrick			6306 Ducketts Lane Elkridge, Md. 21227											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia - Cause Unknown DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity - 34 week gestation DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) N/A														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Aug 14 , 19 86 to , 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE John Van Brakle MD						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Aug 15, 1986				
22d. PHYSICIAN'S NAME (Type) VAN BRAKLE						22e. ADDRESS HOLY CROSS HOSPITAL OF SILVER SPRING								
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 9/24/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville, Maryland						
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc.						ADDRESS 1331 Rockville Pike Rockville Md. 20852		25a. REC'D BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE 				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00-10433

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John L Beador			2a. DATE OF DEATH MONTH DAY YEAR 09-07-86		2b. HOUR 1135P	
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 11 17		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meter Installer		12b. KIND OF BUSINESS OR INDUSTRY PEPCO
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Adlor		15. MOTHER'S MAIDEN NAME Elizabeth Williams		13e. STREET ADDRESS / ZIP CODE 3510 Anderson Road 20895		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT Helen A. Beador ADDRESS same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of The Lung DUE TO, OR AS A CONSEQUENCE OF: (b) metastatic to The Brain DUE TO, OR AS A CONSEQUENCE OF: (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 6 mo
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 71 to Sept 7 19 86 , that (I) (we) last saw the deceased alive on Sept 7 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE G. Stuart Scott, M.D.				DEGREE 		22c. DATE SIGNED Sept 8/9 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Stuart Scott, M.D.				22e. ADDRESS 6320 Democracy Blvd., Bethesda, Md. 20817		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 11, 86		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Georges Md.
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR SEP 15 1986		
25b. REGISTRAR'S SIGNATURE J. Davidson						

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00-18447

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RICHARD M. BEARD			2a. DATE OF DEATH MONTH DAY YEAR 09 17 86		2b. HOUR 4:30 PM		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 12 10 24		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVERSPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECT. ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVERSPRING				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 570 Gilmore Drive 20901	
14. FATHER'S NAME FIRST MIDDLE LAST Alvin Beard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eula Stone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 453-26-9634		17. INFORMANT ADDRESS Helen C. Beard Wife Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Anoxic encephalopathy Approximate interval between onset and death: 3 days						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/14 1986		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE 10313 GEORGIA AVE S.S. MD 20902			
22a. I certify that (1) this hospital attended the deceased from 9/16 1986 to 9/17 1986 , that (2) (we) last saw the deceased alive 9/16 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did not) view the body after death.							
22b. SIGNATURE Alan I. Kermaier, MD				DEGREE MD		22c. DATE SIGNED 9/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN I. KERMAIER, MD				22e. ADDRESS 10313 GEORGIA AVE S.S. MD 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sep. 18, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR SEP 19 1986			
				25b. REGISTRAR'S SIGNATURE Juha J. J. J.			

05-18447

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Texas
The following information was obtained from the records of the Texas Department of Transportation for the year 1944.

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00-19019

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Mercedes Bensimon</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9-21-86</i>		2b. HOUR <i>2:20 P.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>December 4, 1912</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Algeria</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Dress-Maker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ladies Wear</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Chevy Chase</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Aaron Sabbah</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Esther Mergui</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>578-64-6908</i>	
17. INFORMANT ADDRESS <i>Chevy Chase, Md. 20815</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>arrhythmias</i> DUE TO, OR AS A CONSEQUENCE OF, (c) <i>hypertension</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>end stage renal disease</i>							
19a. DATE OF OPERATION <i>Surgical 86</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>pericardiectomy</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/30</i> , 19 <i>86</i> , to <i>9/2</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>9/2</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>K. Nossuli</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/2/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>K. NOSSULI</i>		22e. ADDRESS <i>5620 Shiloh Drive Bethesda</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/22/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Adelphi; P.G.; Maryland</i>	
24. FUNERAL DIRECTOR <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR <i>SEP 23 1986</i>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "at work" and there is any injury, or other traumatic event, the medical examiner should be notified at once.

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00-18099

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Milton C. Beverly					2a. DATE OF DEATH MONTH DAY YEAR September 12, 1986			2b. HOUR 6:10PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
11. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Animal Caretaker		12b. KIND OF BUSINESS OR INDUSTRY NNMC	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15526 Holly Grove Rd/20904	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Beverly, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Stockett				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-12-0534		17. INFORMANT ADDRESS Edna Beverly (wife) same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Hepatic encephalopathy									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/29/86 , 19 86 , to 9/12 , 19 86 , that (I) (we) lost saw the deceased alive on 9/12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Raymond Bass				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS				22e. ADDRESS 3941 Ferrara Dr. Wheaton Md 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-17-86		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. MD			
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR SEP 16 1986		25b. REGISTRAR'S SIGNATURE George R. Snowden	

OPTIONAL FORM NO. 10

00-17335

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS JEANETTE BING			2a. DATE OF DEATH MONTH DAY YEAR 9/1/86		2b. HOUR 3:00p		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 18 1936		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 50 YRS 14	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 404 W. DeerPark Rd., Gaith.MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EEO Officer		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 404 W. Deer Park Road		13f. STREET ADDRESS 20760		14. FATHER'S NAME FIRST MIDDLE LAST Hugh Marrow, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Webb	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. 577-42-7236		17. INFORMANT Kathlyn Marrow		17. ADDRESS 12 S. VanDorn St., Alex. Va. 22304	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): metastatic breast ca DUE TO OR AS A CONSEQUENCE OF (b): DUE TO OR AS A CONSEQUENCE OF (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 mo's
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 8/11/86 , 19 86 , to 9/1 , 19 86 , that (I) (we) last saw the deceased alive on 8/20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.							
22b. SIGNATURE Daniel Rosenblum				DEGREE MD		22c. DATE SIGNED 9/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM, M.D.				22e. ADDRESS 10400 CANN AVE, KENSINGTON, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-7-1986		23c. NAME OF CEMETERY OR CREMATORY CHURCH CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HENDERSON	
24. FUNERAL DIRECTOR NAME JOHNSON & JENKINS				ADDRESS 716 Kennedy St. N.W. Wash D.C.		25a. DATE REC'D. BY REGISTRAR SEP 8 1986	
				25b. REGISTRAR'S SIGNATURE John Davidson			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN UNUSUAL DELAY IS NECESSARY, PLEASE ADVISE THE FUNERAL DIRECTOR.
PAGE 1 OF THIS CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PARTIAL INFORMATION TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR YOUR FILES.
PAGE 2 OF THIS CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1C, GIVE PARTIAL INFORMATION TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH.
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF PUBLIC HEALTH RECORDS, 201 N. WILKINSON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL.

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		6 2 2 2 8	
FOR STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1- DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
Mildred CLARK Bley		2b. HOUR	
3. SEX FEMALE		4. RACE CAUC.	
5. DATE OF BIRTH		6. AGE (IN YEARS)	
Jan. 8, 1908		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
IOWA		USA	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Sandy Spring		Friends Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Secretary		(Unknown)	
13a. STATE		13b. COUNTY	
MD.		MONT.	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
SANDY SPRING		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS		13f. STREET ADDRESS	
17301 Quaker Lane		20860	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
HERBERT CLARK		JENNY SPENCER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
NO		218-10-8277	
17. INFORMANT		ADDRESS	
Camilla O. McRory		414 Hungerford Dr. Rockville, Md. 20850	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
Hypothyroidism and Organic brain syndrome			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION			
STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY)	
M.D. Assistant		MEDICAL EXAMINER	
DATE SIGNED		9/8/86	
EXAMINER'S NAME		ADDRESS	
William M. Zane, M.D.		111 Penn St. Balto.MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		SEPT. 10, 1986	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
PARKWOOD CEMETERY		BALTIMORE BALTIMORE MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME		25b. REGISTRAR'S SIGNATURE	
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879		SEP 10 1986	

00-1385

2025 COLTON (PDS)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		4:55P M	
Rose Mary Klick		Sept. 22 1986			
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	94 YRS.	IF UNDER 24 HRS	
		Nov. 19 1891			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Nebraska	USA		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring	1617 Oaklawn Court		Homemaker	own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Montgomery	Silver Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1617 Oaklawn Court 20903	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Joseph Geris		Rose Mary Campbell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS	
N/A		N/A		Samuel S. Blick-husband-(same as 13e)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiogenic Heart Failure.</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>September 19, 74</u> to <u>Sept. 22, 1986</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>9-17</u> 19 <u>86</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Robert Kramer MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>9/23/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Robert Kramer, MD		10313 Georgia Avenue, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	9-26-1986	Gate of Heaven Cemetery	Silver Spring Montgomery Md.		
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		SEP 25 1986	

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00-19224

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN.
Mary Bolling					9-18-86				3:05	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	Black	11-17-07			79 YRS.	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.	USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	Grass View Health Care Center				Seamstress		Self Employed			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE				
Washington D.C.						920 Longfellow Street, N.W. 99999				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS						
Joseph Bolling		Ellen Toms								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS						
no	577-46-6479	Margaret Page		4813 Illinois Ave Wash. D.C.						
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral Arteriosclerosis</u> (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u> APPROXIMATE PERIOD BETWEEN ONSET AND DEATH <u>months</u> <u>years</u> <u>11</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>2/4/86</u> to <u>late</u> that (I) (we) first saw the deceased alive on <u>9/18/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>Thos G. Ward</u> DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/18/86</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Thos G. Ward		6114 Robinson Rd, Bethesda 20819								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		Sept 22 1986		Lincoln Memorial		Suitland Maryland				
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
McGuire Funeral Service		7400 Georgia Ave. D.C.		SEP 25 1986						

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DHMH - 16 50M 4/83
(VRA 15, 4)

00-17318

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove and retain page 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) JOHN TOLSON BONIFANT					2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 4, 1986			2b. HOUR 2 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 4, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SANDY SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 800 ASHTON ROAD				12a. USUAL OCCUPATION (IF DECEASED OUT OF WORKING LIFE) DIRECTOR ADM. SERVICES		12b. KIND OF BUSINESS OR INDUSTRY WATER UTILITY	
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN SANDY SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 800 ASHTON ROAD 20860	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE F. BONIFANT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NAN - TOLSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II 579-16-7834		17. INFORMANT Vera T. Bonifant Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic adenocarcinoma of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 86 to 19 , that (I) (we) last saw the deceased alive on 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jules R. Lodish</i>				DEGREE M.D.				22c. DATE SIGNED 9/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JULES R. LODISH				22e. ADDRESS 2901 Olney-Sandy Spring Rd. Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 6, 1986		23c. NAME OF CEMETERY OR CREMATORY BONIFANT FAMILY CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE COLESVILLE MONT. MD.			
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR SEP 8 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

00-17318

1



0-17967

Film 6620 item 17

FOR 10/6/86 rja
1- STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 6

2 6 2 3 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Katherine M. Boozell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Sept. 5 1986</i>		2b. HOUR <i>945 P.M.</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>October 5, 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Iowa</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>10406 Montrose Avenue</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>NIH</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Gerd Beneke</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Tobin</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>478-40-6101</i>		17. INFORMANT <i>Dixon Daughter</i> ADDRESS <i>10712 Jamaica Drive Silver Spring, Md. 20902</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(b)

Coronary artery disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

None

19a. DATE OF OPERATION <i>—</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. — 19 —</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>	21f. LOCATION STREET <i>—</i>	CITY OR TOWN <i>—</i> COUNTY <i>—</i> STATE <i>—</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>12/3/60</i> , 19 <i>86</i> , to <i>present</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>Aug. 1</i> , 19 <i>86</i> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>John B. Umhau</i>	DEGREE <i>MD</i>	22c. DATE SIGNED <i>9/6/86</i>	22d. ADDRESS <i>8805 Conn. Ave. Chevy Chase, Md</i>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John B. Umhau MD</i>		22f. ADDRESS <i>8805 Conn. Ave. Chevy Chase, Md</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Sept. 12, 1986</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Summit Hill Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Pocahontas</i> COUNTY <i>Pocahontas</i> STATE <i>Iowa</i>
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 15 1986</i>	
500 University Boulevard, W. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE <i>John B. Umhau</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 2, 3 and 4 and return them to the funeral director. Page 4 may be retained by the funeral director.

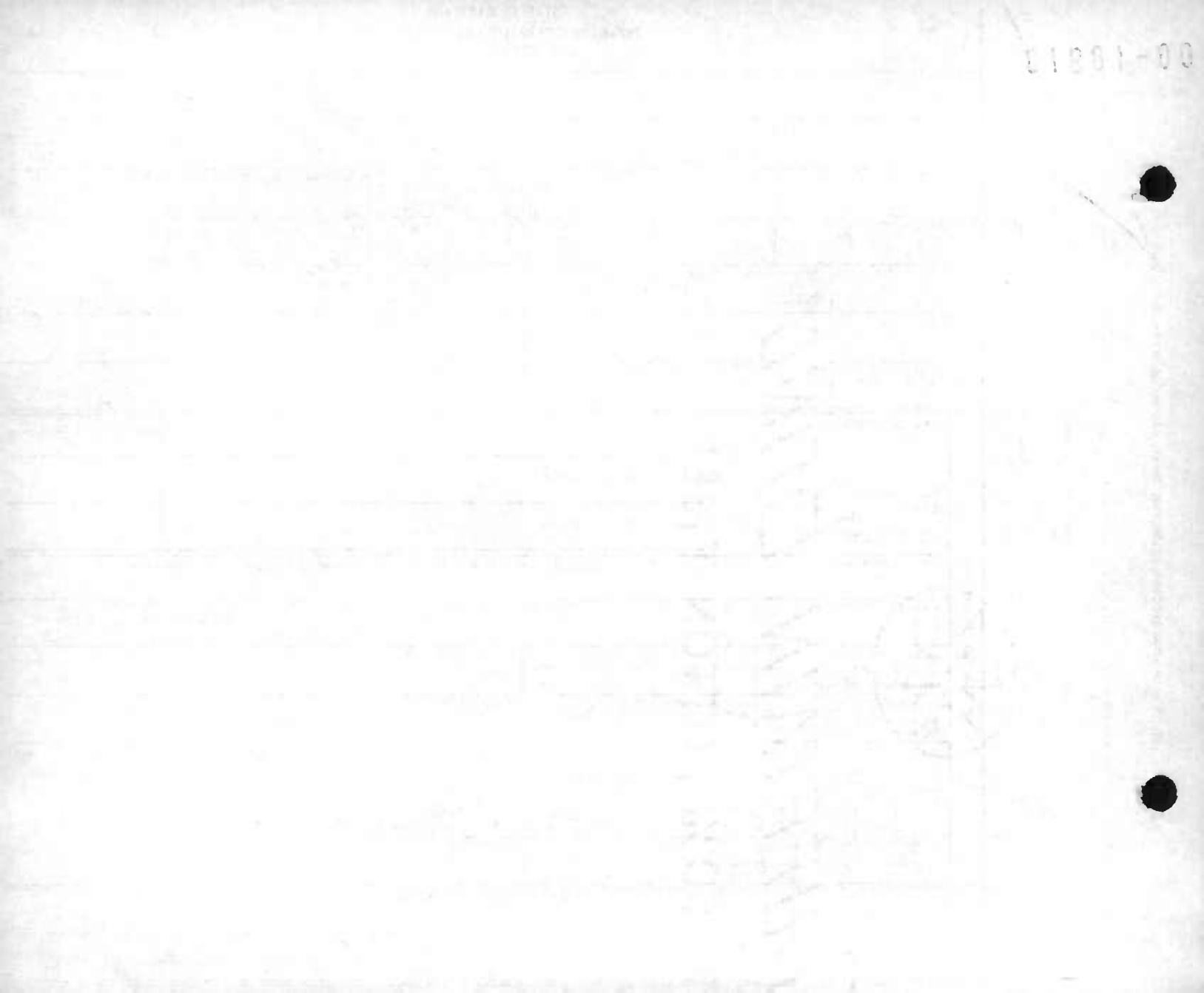
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERNEST W. BOWEN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 21, 1986			2b. HOUR 3:17 PM			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 05 13 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nrsq. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanical Engr.		12b. KIND OF BUSINESS OR INDUSTRY Allied Chem.	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 76 Deer Park St. 20879	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Bowen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella F. Whiting					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 227-07-1060		17. INFORMANT Elizabeth Paul same as #13-e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) gallbladder cancer DUE TO, OR AS A CONSEQUENCE OF (c) longstanding								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION ----		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ----				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 86 , to 9/21 , 19 86 , that (I) (we) lost saw the deceased alive on 9/19 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ira Paul Kreftinz</i>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira Paul Kreftinz, M.D.				22e. ADDRESS 2101 Medical Park Drive Silver Sprg Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/25/86		23c. NAME OF CEMETERY OR CREMATORY Blandford		23d. LOCATION CITY OR TOWN COUNTY STATE Petersburg, Virginia			
24. FUNERAL DIRECTOR NAME U.T. Morris 103 S. Adams St.				25a. DATE REC'D. BY REGISTRAR SEP 23 1986		25b. REGISTRAR'S SIGNATURE <i>J. H. Davidson</i>			

00-10813



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 3 4

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Lillian J, Bower			2a. DATE OF DEATH MONTH DAY YEAR 9-24-1986			2b. HOUR 12:15 P.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-22-1898		6 AGE (IN YEARS LAST BIRTHDAY) 88		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN) Virginia		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea-Woodland Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ruffin Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-40-2055			17 INFORMANT 8420 S Manchester Rd, apt 5 Mary Ann Hutton Sil. Spr. Md. 20901						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>June</u> 19 <u>78</u> to <u>9/24</u> 19 <u>86</u> , that (1) <u>we</u> last saw the deceased alive on <u>9/23</u> 19 <u>86</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.									
22b. SIGNATURE <u>James R Coleman MD</u> DEGREE						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES R. COLEMAN</u>						22e. ADDRESS <u>3929 FERRARA DRIVE</u> <u>WHITEATON, MARYLAND 20906</u>			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 9-28-1986		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION Smithfield, Virginia		
24. FUNERAL DIRECTOR <u>Arthur Walters</u> Takoma Fun Home Wash, D.C., 20012						25. DATE REC'D. BY REGISTRAR SEP 29 1986			
25. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>									

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified for further investigation.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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00-17922

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frederic R. Bresnick			2a. DATE OF DEATH MONTH 09 DAY 11 YEAR 86			2b. HOUR 11:50 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 9 YEAR 37		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boston, Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dept. of Education		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) D.C.			13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6364 31st Place, N.W. (20015)	
14. FATHER'S NAME FIRST Jacob MIDDLE Bresnick LAST Bresnick			15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Neitlich LAST Neitlich							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Korean Conflict 024-05-6565			17. INFORMANT Hollywood, Fla. 33021 Allan J. Bresnick; 4300 Casper Court;				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 24 hours APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None										
19a. DATE OF OPERATION 9/11/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiac arrest			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2) Cardiac arrest				
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home			21e. LOCATION STREET 31st Place CITY OR TOWN Washington COUNTY D.C. STATE D.C.							
22a. I certify that (i) (this hospital) attended the deceased from September 11, 1986 to 9/11/86 that (i) (we) last saw the deceased alive on 9/11/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (i) (we) (did) (did not) view the body after death.										
23a. SIGNATURE Richard Schenfeld MD			23b. DEGREE MD			23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23d. DATE SIGNED September 11, 1986	
24a. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Schenfeld MD			24b. ADDRESS 5530 Wisconsin Ave Chevy Chase Md 20815							
25a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			25b. DATE 9/12/86			25c. NAME OF CEMETERY OR CREMATORY Chevera Kadusha of Boston; Woburn, Mass.			25d. LOCATION CITY OR TOWN Woburn, Mass. COUNTY Mass. STATE Mass.	
26. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852						27a. DATE REC'D. BY REGISTRAR SEP 15 1986		27b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

35251-00

0-17405

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert this page in the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic condition, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther Brickner					2a. DATE OF DEATH MONTH DAY YEAR 9/5/86		2b. HOUR 5:17 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4/18/14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -----	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS (20852) 6050 California Circle, #101	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Saltzman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Weiner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 079-22-9372		17. INFORMANT Rockville, Md. 20852 Mel Brickner; Son; 6050 California Circle, #101;					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: (c) CEREBRAL ARTERIOSCLEROSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN 1 MONTH 5 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GASTRIC ULCER, PARKINSON'S DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/25 19 85 to 9/5 19 86 that (we) last saw the deceased alive on 9/5 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or we) (did) (did not) view the body after death.									
22b. SIGNATURE Steven Lipson		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN LIPSON				22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/7/86		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Olney; Montgomery; Maryland			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. DIED IN BY RETURNCAR SEP 9 1986		25b. REGISTRAR'S SIGNATURE [Signature]			
1170 Rockville Pike; Rockville, Md. 20852									

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00-17129

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 2 3 7	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Harry P. Brooks					2a. DATE OF DEATH MONTH DAY YEAR September 1, 1986			2b. HOUR 7:41p M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Translator		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4712 Edgefield Road/20814			
14. FATHER'S NAME FIRST MIDDLE LAST Not Available					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Not Available						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 066-16-3733		17. INFORMANT ADDRESS Marion S. Brooks, same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastric Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Site Unknown</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10-12 hr.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 26</u> 19 <u>86</u> to <u>Sept 1</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 26</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William F. Lockett</u> DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-1-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Lockett MD.					22e. ADDRESS 5000 Reno Road N.W. Washington, D.C. 20008						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home's 7557 Wisconsin Ave. Bethesda, MD 20814										25. DATE REC'D. BY REGISTRAR PA SEP 5 1986	
26. REGISTRAR'S SIGNATURE <u>J. H. Davidson</u>											

00-12153

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the hospital, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hospital 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
ELSBETH JONAS BROTMAN		SEPTEMBER 1 1986		9:30 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
FEMALE	CAUCASIAN	MONTH DAY YEAR	62 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
GERMANY	UNITED STATES		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	NAVAL HOSPITAL	SALES	Dress		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND	MONTGOMERY	SILVER SPRING	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3112 HELSEL DRIVE 20906	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
LOUIS JONAS		ELLA BUCHHEIM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		091-22-8015		GERALD BROTMAN, 3112 HELSEL DRIVE, SILVER SPRING, MD 20906	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC GASTRIC CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 25, 1986, to SEPTEMBER 1, 1986, that (I) (we) last saw the deceased alive on SEPTEMBER 1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Edward P. Fox MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2 Sept. 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. FOX, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/4/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Park Cemetery	
23d. LOCATION Paramus, N.J. Bergen Co.		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR SEP 8 1986		25b. REGISTRAR'S SIGNATURE John Anderson	

BP

78871-

0-17313

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSMIT TO DIVISION OF VITAL RECORDS WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Glenn F. Browning			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 9 3 1986			2b. HOUR 11:40 AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 2 DAY 26 YEAR 12	6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD MONTH 9 DAY 3 YEAR 1986		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Credit Field Man		12b. KIND OF BUSINESS OR INDUSTRY Farm Credit
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Monrovia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3923 Barthlows Rd. 21770			
14. FATHER'S NAME FIRST Ferdinand MIDDLE D. LAST Browning				15. MOTHER'S MAIDEN NAME FIRST Eunice MIDDLE May LAST Lewis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-24-9925		17. INFORMANT 9101S Liberty Knolls Ct J. Pinoake Browning, Union Bridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Coronary arteriosclerosis (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Tauber			TITLE (SPECIFY) Deputy			DATE SIGNED 9-4-86		
EXAMINER'S NAME (TYPE OR PRINT) John Tauber			ADDRESS 8218 Wisconsin Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Sept. 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE	
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md. ADDRESS					25a. DATE REC'D. BY REGISTRAR SEP 8 1986		25b. REGISTRAR'S SIGNATURE Gutha Davidson	

0-17313

Glenn F. BROWNING

Virginia

USA

x

Rockville

Greene Field Man Farm Greer
Hampden County,

Virginia

Frederick

Monrovia

x

3923 Taylors Rd. 22270

Ferdinand

D.

Monrovia

Justice

Key

Lewis

9101 Liberty Knolls Dr
J. Kincaid Browning, Union, Md.

217-21-992

No



Creation

Sept. 2, 1980

Westview

Baltimore, Maryland

Oliver L. Wolcott, P.O. Box 1000, Newburg, Md.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 4 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALDO JACOB BRUBACHER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20, 1986			2b. HOUR 3:45 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 18, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION KENSINGTON GARDENS N. HOME				12a. USUAL OCCUPATION (TYPE AND MOST OF WORKING LIFE) Fireman	
						12b. KIND OF BUSINESS OR INDUSTRY Fire Dept.	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3714 John Carroll Dr. 20832	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Henry Brubacher				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna - Hubin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-30-4492		17. INFORMANT ADDRESS Raymond A. Brubacher Same as # 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Osteomyelitis of left clavicle, abscess of chest wall

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that we (this hospital) attended the deceased from Sept 10, 1986 to Sept 20, 1986, that (I) (we) lost
saw the deceased alive on Sept 19, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Arthur S. Bresler M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-20-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ARTHUR S. BRESLER		22e. ADDRESS 10881 Lockwood Dr. Silver Spring, Md. 20901			

23a. BURIAL, CREMATION, REMOVAL 15P BURIAL		23b. DATE SEPT. 23, 1986		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION SILVER SPRING MONT. MD	
--	--	------------------------------------	--	---	--	--	--

24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879		25a. DATE OF DEATH BY REGISTRAR SEP 23 1986		25b. REGISTRAR'S SIGNATURE	
--	--	---	--	----------------------------	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

BP

[illegible]

PAGE TWO

00-20026

FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 4 1

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Annale H. Bullas			2a. DATE OF DEATH MONTH DAY YEAR Sept. 30 1986			2b. HOUR 8:15 AM	
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bullas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Roundtree		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 70 0833	
17. INFORMANT E. Wayne Roundtree		ADDRESS P.O. Box 55		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer respiratory tract DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Yeast		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yeast	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR August 1 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (SAY HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this body was attended to the deceased from August 1 , 19 86 , to September 30 , 19 86 , that (we) last saw the deceased alive on September 4 , 19 86 , and that in our opinion death occurred on the date and hour and from the causes stated above (we) did not find any other death.							
22b. SIGNATURE Benjamin Pearson, MD		DEGREE MD		22c. DATE SIGNED 9-30-86		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 3, 1986		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION CITY OR TOWN STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes ADDRESS Arlington, Va. 22201				25. DATE RECD. BY REGISTRAR OCT 06 1986		25b. REGISTRAR'S SIGNATURE Philip D. Olney, MD	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Cleared By Dr. John Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified immediately.

VOID

CERTIFICATE # 86-26242

00-182-13

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 and any day injury, or other traumatic event, the medical examiner must be called at once.

BP _____

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 4 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frankie Viola Burns</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Sept. 12, 1986</i>		2b. HOUR <i>2:00A.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 29, 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Miss.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Ellerman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Augusta Cruse</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>			
16b. SOCIAL SECURITY NO. <i>437-78-3318</i>		17. INFORMANT ADDRESS <i>Maudenya Zinke same as #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF <i>CVA</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9/11 1986</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>11120 N H An St, Md 20904</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/11</i> 19 <i>86</i> to <i>9/12</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>9/11</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Michael Leibovitch</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12 Sept 86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael Leibovitch</i>		22e. ADDRESS <i>11120 N H An St, Md 20904</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sep. 19, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Bap. Ch. Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Winnsboro Franklin Louisiana</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Francis J. Collins, Jr.</i> <i>500 University Blvd. West, Silver Spring, Md.</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>SEP 18 1986</i>			

20901

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SECTION FIBER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 4 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bustar Olive Bea Bushey			2a. DATE OF DEATH MONTH DAY YEAR Sept. 10, 1986		2b. HOUR 1553
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 3 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker	12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. STATE PA			13b. COUNTY Adams	13c. CITY OR TOWN Biglerville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Beamer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Taylor		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Donald Bushey 60 Gurnsey Rd Biglerville PA 17307	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

Surgical revision of total hip

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 9/10/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Failed total hip replacement	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/9, 1986, to 9/10, 1986, that (I) (we) last saw the deceased alive on 9/10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE R. Marshall Freeman	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/10/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. MARSHALL FREEMAN, MD		22e. ADDRESS 9715 Medical Center Dr., Rockville, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-13-86	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem	23d. LOCATION CITY OR TOWN COUNTY STATE Arendtsville Adams PA
24. FUNERAL DIRECTOR NAME Monahan Funeral Home		125 Carlisle St Gettysburg PA 17325	25a. DATE REC'D. BY REGISTRAR SEP 15 1986
		25b. REGISTRAR'S SIGNATURE Julia Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1, 2, and 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified as soon as possible.

ST. PAUL, MINN.

APR 10, 1901

WILLIAM H. HARRIS, JR.

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WILLIAM H. HARRIS, JR.

WILLIAM H. HARRIS, JR.

WILLIAM H. HARRIS, JR.

WILLIAM H. HARRIS, JR.

WILLIAM H. HARRIS, JR.

WILLIAM H. HARRIS, JR.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH R. CALLAHAN			2a. DATE OF DEATH MONTH DAY YEAR 9 14 86		2b. HOUR 11:00 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 18 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 601 Bonifant Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY House of Representatives
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John M. Flynn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Collins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 016-05-3475		17. INFORMANT John H. Callahan Husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>WIDESPREAD METASTATIC DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADENOCARCINOMA OF BREAST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 1</u> , 19 <u>85</u> , to <u>SEPT 14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>SEPT 12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard P. Delaney</u> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-14-86	
22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep. 18, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Great Barrington Mass.		23e. DATE REC'D. BY REGISTRAR SEP 18 1986			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25b. REGISTRAR'S SIGNATURE			
500 University Blvd., W. Silver Spring, Md.					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B then any injury, or other traumatic event, the medical examiner must investigate the medical history of the deceased.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filing by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LLOYD DALE CAMPBELL			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 11 1986			2b. HOUR A M 2:00			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 8 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
13a. STATE VIRGINIA		13b. COUNTY ARLINGTON		13c. CITY OR TOWN ARLINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1335 So. COLUMBUS STREET 22204	
14. FATHER'S NAME FIRST MIDDLE LAST LLOYD ERNEST CAMPBELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE DALLMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1940-1961		17. INFORMANT ADDRESS SARA CAMPBELL, 1335 SO. COLUMBUS STREET,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ESOPHAGEAL CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that XX (this hospital) attended the deceased from SEPTEMBER 9 , 19 86 , to SEPTEMBER 11 , 19 86 , that XX (we) last saw the deceased alive on SEPTEMBER 11 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) (do not) view the body after death.									
22b. SIGNATURE R. P. Dolan MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. P. DOLAN, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 13		23c. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA			
24. FUNERAL DIRECTOR NAME IVES-PEARSON FUNERAL HOMES ARLINGTON, VIRGINIA				25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE			

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET		MIDDLE W.		LAST CARLTON		2a. DATE OF DEATH MONTH DAY YEAR September 29, 1986		2b. HOUR 11 15 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 16, 1919		6. AGE (IN YEARS (LAST BIRTHDAY)) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11911 Ivanhoe Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Secretary		12b. KIND OF BUSINESS OR INDUSTRY VITRO	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11911 Ivanhoe Street 20902	
14. FATHER'S NAME FIRST MIDDLE LAST Richard E. White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby E. Ticer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-5860		17. INFORMANT sister Mary Coppinger		18. ADDRESS 1620 Neeley Road Silver Spring, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>WIDESPREAD METASTATIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DISEASE</u> <u>CARCINOMA, PRIMARY UNKNOWN</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Less than 2</u> <u>years</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
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21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					

27a. I certify that (I) (this hospital) attended the deceased from JAN 80, to Sept 19, 1986, that (I) (we) last saw the deceased alive on Sept 19, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

72b. SIGNATURE D. G. Watkins DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 72c. DATE SIGNED 9-30-86

72d PHYSICIAN'S NAME (TYPE OR PRINT) RAFAEL A. MATHIAS 72e ADDRESS 13018 Georgia Ave. Wheat

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Oct 3 86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Barblow Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Barboursville</i> COUNTY <i>Mingo</i>
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24. FUNERAL DIRECTOR NAME	<i>Francis J. Collins, Jr.</i>	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
	ADDRESS <i>500 University Blvd. West, Silver Spring, Md.</i>	<i>DEC 10 1986</i>	<i>[Signature]</i>

TO HOSPITAL, OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORT ANK. If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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May 1963 Vol. 1

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year and the progress of the work during the year.

3. The third part of the report deals with the results of the work during the year and the progress of the work during the year.

4. The fourth part of the report deals with the results of the work during the year and the progress of the work during the year.

5. The fifth part of the report deals with the results of the work during the year and the progress of the work during the year.

6. The sixth part of the report deals with the results of the work during the year and the progress of the work during the year.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

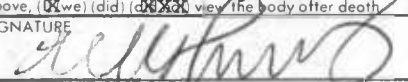
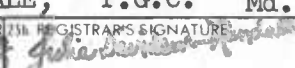
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marjorie Ann Cattlett			20. DATE OF DEATH MONTH DAY YEAR September 11, 1986		2b. HOUR 11:55 P_M
1 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 26, 1926		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 30. STATE Virginia	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN Blacksburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 221 Craig Dr., NW 24060	
14. FATHER'S NAME FIRST MIDDLE LAST GUY PAUL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ZORA MOFFETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 490-24-4085	17. INFORMANT ADDRESS Mr. Wayne S. Cattlett, Husband same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF BONE MARROW REPLACEMENT (b) MULTIPLE DUODENAL ULCERS, ESOPHAGITIS DUE TO, OR AS A CONSEQUENCE OF (c) DIFFUSE HISTIOCYTIC LYMPHOMA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 11, 1986 , to September 11, 1986 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on September 11, 1986 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED 9/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E C KOHN MD		22e. ADDRESS National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 9-13-1986	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		ADDRESS 20910 SILVER SPRING, Md.		25a. DATE REC'D. BY REGISTRAR SEP 16 1986	
				25b. REGISTRAR'S SIGNATURE 	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 4 9

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN.	
Rachel Helena Chamow		Aug. 25 1986		11:15am	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	YRS.	MONTHS	DAYS
		8 25 86			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
MD			Montgomery MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Adventist Hospital				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Montgomery	Bethesda	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4528 South Chelsea lane 20814	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Steven Mark Chamow		Judith Lee Adaek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Extreme Prematurity					
DUE TO, OR AS A CONSEQUENCE OF (b) (Non viable)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Subramanian		MD			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL CREMATION REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Hospital					
24 FUNERAL DIRECTOR'S NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
				SEP 30 1986 Julia Davidson-Rudner	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Bing Chin					2a. DATE OF DEATH MONTH 09 DAY 09 YEAR 86 2b. HOUR 3:16 PM				
3. SEX Male		4. RACE Oriental		5. DATE OF BIRTH MONTH 10 DAY 27 YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13e. STREET ADDRESS / ZIP CODE 10105 Brock Drive		20903	
14. FATHER'S NAME FIRST Sing MIDDLE Ming LAST Chin					15. MOTHER'S MAIDEN NAME FIRST Fung MIDDLE Song LAST Chow				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT (wife) Toy King Woo Chin ADDRESS (same as 13a)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARDS and renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Generalized sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Perforated diverticulitis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 9-6-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated diverticulitis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY 19 P.M. 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a. I certify that (I) (the hospital) attended the deceased from 9-6-86 to 9-9-86 , that (I) (we) lost the deceased alive on 9-8-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.									
22b. SIGNATURE Ira N Brecher DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 9-9-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA N BRECHER MD					22e. ADDRESS 2101 Medical Park Dr Silver Spring, MD 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-17-1986		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN Adelphi COUNTY Prince Georges STATE Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home ADDRESS 11800 N.H. Ave., Silver Spring, Md.				25a. DATE RECEIVED BY REGISTRAR SEP 15 1986 25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8020251				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE K. CLARKE					2a. DATE OF DEATH MONTH DAY YEAR 9 11 86				2b. HOUR 6:45 AM
3. SEX F	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 5 2 00		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 86		IF UNDER 1 YEAR MONTHS DAYS 86		IF UNDER 24 HRS. HOURS MIN. 6 45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife		
13a. STATE MD.	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2318 Hermitage Ave. 20902					
14. FATHER'S NAME FIRST MIDDLE LAST William R. Kelly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Chaney			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				
16b. SOCIAL SECURITY NO. 213-50-8655		17. INFORMANT Dorothy Vechery			ADDRESS 2740 N.W. 106th Ave. Coral Springs, Fla. 33065				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PARKINSONS DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CEREBROVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 9-11-1986 to 9-11-1986 , that (1) (two) last saw the deceased alive on above (1) (two) (did) (did not) view the body after death.									
22b. SIGNATURE Charles Benner MD		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-11-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES BENNER MD		22e. ADDRESS 11161 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/13/1986		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Georges Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE SEP 18 1986					
25c. ADDRESS 500 University Blvd. West, Silver Spring, Md. 20901									

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 6 2 6 2 5 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HELEN B. CLARK			2a. DATE OF DEATH MONTH DAY YEAR 9 / 20 / 1986		2b. HOUR 3:10 P.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 9 / 11 / 20		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Cr. MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher	12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) D.C.	13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1612 Crittenden Street, N.E.	
14. FATHER'S NAME FIRST MIDDLE LAST Wolsey M. Blakely		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ollie Pyles			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-20-8992		17. INFORMANT ADDRESS Mr. Walter V. Clark/husband/same as 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

septic shock

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 day

DUE TO, OR AS A CONSEQUENCE OF

(b) Probable Urinary Tract Infection

1 day

DUE TO, OR AS A CONSEQUENCE OF

(c) Alzheimer's Disease

@ 7 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Decubiti

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF SISTER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 19 82 to sept 19 86, that (I) (we) last saw the deceased alive on 8/22 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Bruce Cooper MD	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/20/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Cooper	22e. ADDRESS 6525 Belcrest Rd Hyattsville, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-25-86	23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md.
24. FUNERAL DIRECTOR NAME John T. Rhines Co. 3015 12th St. N.E., D.C. 20017		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 23 1986 Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-19583

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 5 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY FRANCES CLARK			2a. DATE OF DEATH MONTH DAY YEAR 9 21 86		2b. HOUR PM 2:50 M	
2. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 6 1902		
6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? US		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) operator		
12b. KIND OF BUSINESS OR INDUSTRY Telephone		13a. STREET ADDRESS / ZIP CODE 10000 Brunswick Av., 20910		13b. CITY OR TOWN Silver Spring		
13c. STATE Maryland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10000 Brunswick Av., 20910		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Ochs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Braitsch		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16b. SOCIAL SECURITY NO. 577 12 7027		17 INFORMANT Joan P. Ruscitto		ADDRESS Spring, Md. 20910		
17b. ADDRESS 601 Sligo Av., Silver		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 days 9 mos 9 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/21 86		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/21 86 to 9/21 86 , that (I) (we) last saw the deceased alive on 9/21 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stephen Selinger		DEGREE MD		22c. DATE SIGNED 9/21/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN SELINGER		22e. ADDRESS 4410 Old Georgetown Rd, Bethesda		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		
23b. DATE Sept. 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		24b. ADDRESS 7557 Wisconsin Av., Bethesda, Md. 20815		25a. DATE REC'D. BY REGISTRAR SEP 29 1986		
25b. REGISTRAR'S SIGNATURE John Davidson		25c. REGISTRAR'S SIGNATURE John Davidson		25d. REGISTRAR'S SIGNATURE John Davidson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other", item 21 is marked "other".

Handwritten notes and diagrams, including a large 'X' mark and various scribbles.

Handwritten notes and diagrams, including a large 'X' mark and various scribbles.

10-17400

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) REGINA C CLOVER			2a. DATE OF DEATH MONTH DAY YEAR 09 04 86			2b. HOUR 23:25 M	
3. SEX Female		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH Takoma PK.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH. Adventist Hosp; Takoma PK, Md 20912		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William R. Cogan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Ann Maroney		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 220-56-5658		17. INFORMANT Mr. Lionel A. Clover		ADDRESS Address Same as No#13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Pulmonary Fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 20, 1986, to Sept 4, 1986, that (I) (we) last saw the deceased alive on Sept 4, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Boris Rabin		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/4/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BORIS RABKIN		22e. ADDRESS 1019 W. Blvd Bldg 2 Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/86		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fredericksburg N/A Va.	
24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 9 1986		25b. REGISTRAR'S SIGNATURE Julia...	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove copies of papers, register and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, etc. IMPORTANT: If item 21 is marked or item 18 also is injury, or other traumatic event, the medical examiner must be notified prior to burial.

00071-0



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 0 2 6 2 5 5	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Silvia Shirley Cocreham			September 23, 1986		5:30 am	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE	WHITE	Aug. 24, 1898	88 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Illinois	U.S.A.		Montgomery County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. PLACE OF BIRTH (CITY OR TOWN, STATE, COUNTRY)	
Rockville	Collingswood Nursing Home		Teacher		Northside School Sys. Texas	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS, CITY, STATE, ZIP CODE
Md. Montgomery		Potomac		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10507 Steamview Court 20854
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
(unknown) Isom		(unknown) Holmes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. DECEASED AT HOME <input type="checkbox"/> IN HOSPITAL <input checked="" type="checkbox"/>		
NO		459-76-3260T		515 Wickerberry Lane, Roswell, Georgia 30075 Shirley Koschella (daughter)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIO SCLEROTIC DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> <u>15 YRS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CEREBRAL ARTERIO SCLEROSIS</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> 19 <u>85</u> to <u>9/23</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>9/7</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. SIGNATURE <u>Thomas E. O'Connor MD</u>		22c. DATE SIGNED <u>9/25/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
THOMAS E. O'CONNOR MD		8218 WILSON AVE, BETHESDA, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		9/26/86		Sunset Mem. Park		San Antonio, Texas
24. FUNERAL DIRECTOR Pyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>SEP 29 1986</u>		

00-10432

00-18490

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26250

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JENNY Elizabeth COHEN			2a. DATE OF DEATH MONTH DAY YEAR 9-16-86			2b. HOUR 7:50 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-15-1890		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6121 Montrose Rd. 20850	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Goldenberg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Finkel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Louis A. Cohen		ADDRESS 9814 Inglemere Drive Bethesda, Md. 20817			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE OSTEOPOROSIS WITH FX'S 10 y. old</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>8-28</u> 19 <u>86</u> , to <u>9-16</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22a. SIGNATURE Loretta J. Albiol, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-16-86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) LORETTA ALBIOL						22e. ADDRESS 6121 MONTROSE Rd.			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			23b. DATE Sept. 17, 1986			23c. NAME OF CEMETERY OR CREMATORY King David Memorial		23d. LOCATION CITY OR TOWN STATE Falls Church, Va.	
24. FUNERAL DIRECTOR Ives-Pearson Funeral Homes - FC, Va.						25a. DATE RECEIVED BY REGISTRAR SEP 19 1986			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copy and send 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, or other traumatic event, the local health officer must be notified at once.



00-18428

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

26251

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MINNIE F. COHEN			2a. DATE OF DEATH MONTH DAY YEAR 9 14 86		2b. HOUR 6:30 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 16 1896		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		13a. STREET ADDRESS / ZIP CODE 1111 UNIVERSITY BOULEVARD, WEST 20902		
16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE 16b. COUNTY MARYLAND MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JACOB FINE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRREL WALDMAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-54-3063		17. INFORMANT JUNE ABEL, 2414 HARMON ROAD, SILVER SPRING, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (1) (this hospital) attended the deceased from 3/25 , 19 82 , to 9/14 , 19 82 , that (1) (we) last saw the deceased alive on 9/12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not move the body after death.						
22a. SIGNATURE Alan Chavaz		DEGREE MD		22c. DATE SIGNED 9/15/86		
22a. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN CHAVAZ		22e. ADDRESS 1525 SHADY GROVE RD, ROCKVILLE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/1986		23c. NAME OF CEMETERY OR CREMATORY SHAARE TEFILA CEMETERY		
23d. LOCATION (CITY OR TOWN) COUNTY STATE WEST ROXBURY, MASS.		24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				
25a. DATE REC'D. BY REGISTRAR SEP 18 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper, pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-18136

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Rose Cohen					2a. DATE OF DEATH MONTH 9 DAY 15 YEAR 86					2b. HOUR 0220 ^{AM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 9 DAY 6 YEAR 16		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST Samuel MIDDLE LAST Himmelfarb					15. MOTHER'S MAIDEN NAME FIRST Jessie MIDDLE LAST Himmelfarb					13e. STREET ADDRESS 19349 Olney Mill Road (20832)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-01-4191		17. INFORMANT Julius T. Cohen; 19349 Olney Mill Rd.; Olney, Md.					ADDRESS 20832		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (c) Chronic active hepatitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months 6 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 6, 19 86 to SEPTEMBER 15, 19 86 , that (I) (we) lost saw the deceased alive on SEPTEMBER 14, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George Bolen		DEGREE M.D.		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED 9/15/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE BOLEN, M.D.		22e. ADDRESS 9711 MEDICAL CENTER DRIVE, #308 ROCKVILLE, MD. 20850									
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 9/17/86		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens; Olney; Montgomery; Maryland			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852					25a. DATE REC'D. BY REGISTRAR SEP 16 1986		25b. REGISTRAR'S SIGNATURE [Signature]				

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00-19721

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sophie Cohen			2a. DATE OF DEATH MONTH DAY YEAR Sept 26 '86			2b. HOUR 6:05p			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Si. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9109 - 2nd Ave., 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Meishe Yosel Kuznets					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sare-Leya Gutersohn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-40-5500		17. INFORMANT ADDRESS Bethesda, Md. 20817 Israel Cohen; 6411 Halbert Rd East;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart failure DUE TO (b) Chronic entry disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years "									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 19 85 to Sept 26 86 that (I) (we) last saw the deceased alive on 9/22/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE Thos G. Ward			22c. DATE SIGNED 9/26/86			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward			22f. ADDRESS 6116 Rockville Rd, Bethesda 20817						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-19-1986		23c. NAME OF CEMETERY OR CREMATORY Natl. Cap. Hebrew Cem./Cap. Hts., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike									
25a. DATE REC'D. BY REGISTRAR OCT 02 1986					25b. REGISTRAR'S SIGNATURE John Davidson				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-18351

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U.S. DEPT. OF JUSTICE

RECEIVED

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U.S. DEPT. OF JUSTICE



0-17942-

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Dorothy D. Cole					2a. DATE OF DEATH MONTH 9 DAY 9 YEAR 86			2b. HOUR 10⁵⁵ A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 8 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 68			7. UNDER 2 YEAR MONTHS YES DAYS NO HOURS NO MIN. NO		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVEN BY SUCH A CLINIC, GIVE STREET ADDRESS) HOLY CROSS Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4714 Falcon St. 20853		
14. FATHER'S NAME FIRST Frank MIDDLE Dunn LAST Dunn					15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Burke LAST Burke						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 196 01 3536		17. INFORMANT ADDRESS Frank E. Cole, husband, see #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METABOLIC LONG CANCER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). CEREBROVASCULAR Accident & Seizures											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from 9/8/86 to 9/9/86 , that (one) one saw the deceased alive on 9/8 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.											
22b. SIGNATURE Ralph Bocca					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Bocca					22e. ADDRESS 14860 Physicians Ln Rockville 20850						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes, PA 300 W. Montgomery Av., Rockville, Md. 20850					25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

BP

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the methodology. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the rate of reaction at different temperatures and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodate in acidic solution. The methodology involves measuring the volume of oxygen gas evolved over time at different temperatures.

2. The second part of the report is a detailed description of the experimental procedure. It includes the list of materials, the apparatus, and the steps of the experiment. The materials are hydrogen peroxide, potassium iodate, sulfuric acid, and sodium metabisulfite. The apparatus includes a conical flask, a delivery tube, a gas syringe, and a water bath. The steps of the experiment are: preparation of the reaction mixture, measurement of the rate of reaction at different temperatures, and calculation of the activation energy.

3. The third part of the report is a discussion of the results. It includes a table of the experimental data, a graph of the rate of reaction against temperature, and a calculation of the activation energy. The table shows that the rate of reaction increases with temperature. The graph shows a linear relationship between the logarithm of the rate of reaction and the reciprocal of the absolute temperature. The activation energy is calculated to be 50 kJ mol⁻¹.

4. The fourth part of the report is a conclusion. It summarizes the findings of the experiment and states that the rate of reaction increases with temperature and that the activation energy of the reaction is 50 kJ mol⁻¹.

5. The fifth part of the report is a list of references. It includes the names of the authors and the titles of the books and articles consulted.

00-17554

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY	MIDDLE K	LAST CONNOLLE	2a. DATE OF DEATH MONTH DAY YEAR Sept. 6 1986	2b. HOUR 11:50 A.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH DAKOTA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.					
10. CITY OR TOWN OF DEATH Silver Spring, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CARRIAGE HILL NURSING CENTER 9101 SECOND AVENUE SILVER SPRING MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER	12b. KIND OF BUSINESS OR INDUSTRY SCHOOL				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN CHERRY CHASE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3405 GLENMOOR DR. / 20815			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM - O'HARA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE - HARRINGTON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MR. PETER CONNOLLE SAME AS #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Constrictive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>								
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —				
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 23, 1986</u> to <u>present</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Aug 28, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>John B. Umhau</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/6/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umhau MD		22e. ADDRESS 8805 Conn. Ave, Cherry Chase Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE SEPT. 8, 1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING, MONT. Co. MARYLAND		
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		ADDRESS SILVER SPRING, MD.		25a. DATE REC'D. BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

b6
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9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0-17416

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

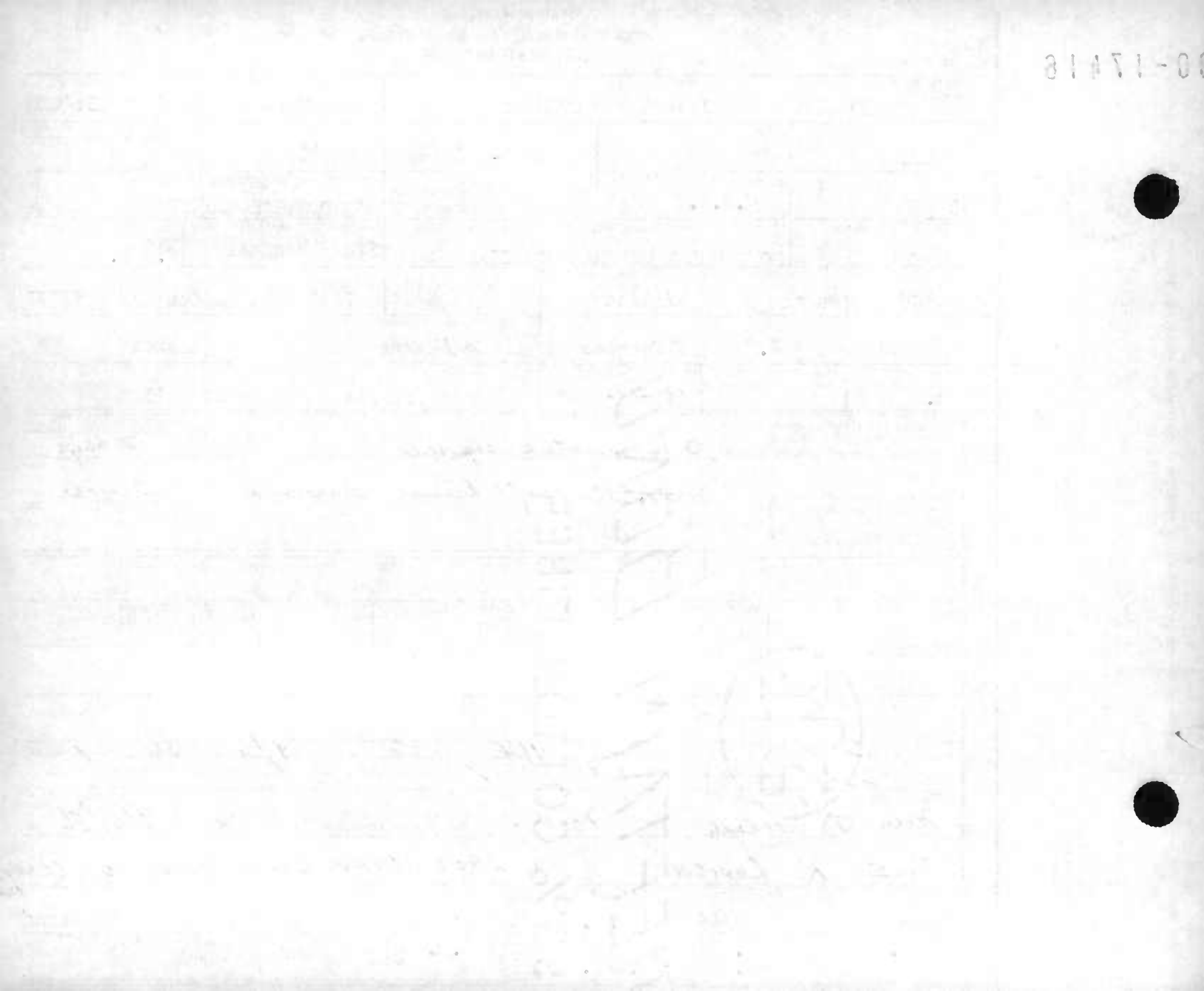
IMPORTANT: If item 23 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 2 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
WILLIAM Joseph CONNORS			SEPTEMBER 06, 1986			3:40AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
MALE	White	MARCH 04, 1946	40 YRS			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.		MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
OLNEY	MONTGOMERY GENERAL HOSPITAL		Staff Manager			C. & P.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland	Howard	Highland	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7167 Deer Valley Road 20777		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
David R. Connors		Catherine Lester					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No.		220-42-1409		Jeanie Connors Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Brain negative sepsis</u>							2 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic soft tissue sarcoma</u>							2 years
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>Dr.</u> (this hospital) attended the deceased from <u>9/4</u> , 19 <u>86</u> , to <u>9/6</u> , 19 <u>86</u> , that <u>I</u> (we) lost saw the deceased alive on <u>9/6</u> , 19 <u>86</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I)</u> <u>(we)</u> <u>(did)</u> (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Jules R. Lodish</u>		<u>M.D.</u>				<u>9/6/86</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JULIES R. LODISH		2901 OLNEY - SANDY SPRING RD., OLNEY, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9/9/86		St. Louis Cemetery		Clarksville Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Leroy M. & Russell C. Witzke, Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, MD. 21034				SEP 9 1986			



00-17553

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) George T. Conway					2a. DATE OF DEATH MONTH DAY YEAR 9-7-86			2b. HOUR 3:10 P.M.	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-31-14		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH DAKOTA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FLIGHT ATTENDANT		12b. KIND OF BUSINESS OR INDUSTRY AIRLINE Co.	
13a. STATE Md.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13709 STONER DR. 20904	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN DAVITT CONWAY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHRYN JOHANNA DEVEREAUX				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-20-0682		17. INFORMANT ADDRESS KATHLEEN C. SWEET (SAME AS #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/3 , 19 86 , to 9/7 , 19 86 , that (I) (we) last saw the deceased alive on 9/7 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Delaney				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Delaney / R. T. Benack MD				22e. ADDRESS 4115 Cole Dr. Wheat on, MD 20904					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-8-1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PGC. MD.			
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO. INC ADDRESS SILVER SPRING, MD				25a. DATE REC'D. BY REGISTRAR 20910 SEP 10 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

Handwritten notes and diagrams, including a large sketch of a structure resembling a house or building with a chimney, and various lines of text.

00-17604

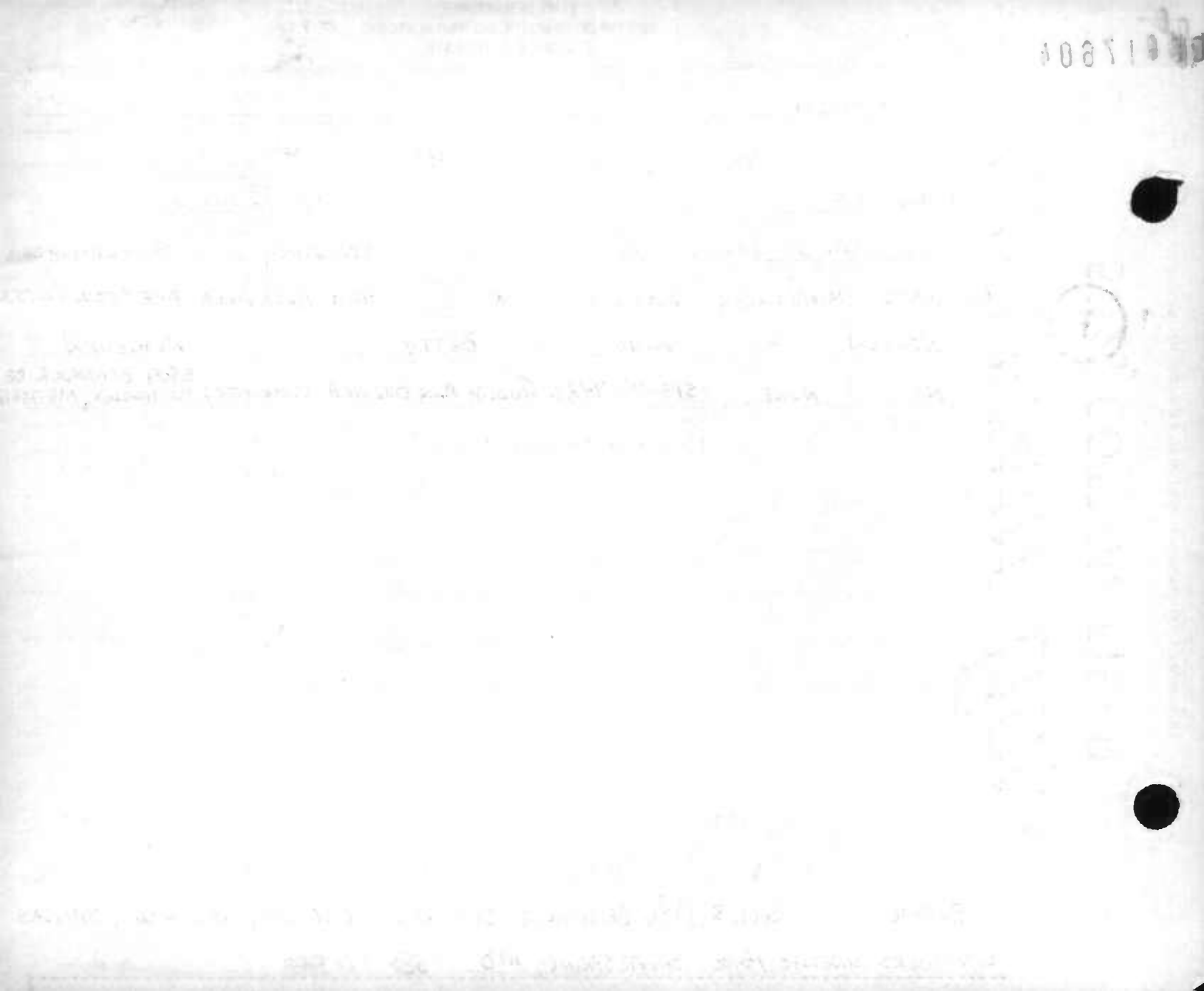
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and sealed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) KAREN L COOKE					2a. DATE OF DEATH MONTH DAY YEAR 9 5 86			2b. HOUR 6:04 PM	
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 23 41		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY SECRETARIAL	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1001 ROCKVILLE PIKE #222 / 20852	
14. FATHER'S NAME FIRST MIDDLE LAST NELSON - KING					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTY - NEWBURN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT JUDITH ANN BREWER (DAUGHTER)		ADDRESS 8509 BRADMOOR DR. BETHESDA, MD. 20817			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Breast Cancer metastatic to Bone marrow, bone, Liver DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/5 , 19 86 , to _____, 19____, that (I) (we) lost saw the deceased alive on 9/5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Jeffrey Drobis					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/5/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY DROBIS					22e. ADDRESS 10500 SUMMIT AVE KENSINGTON MD 20895				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT. 8, 1986		23c. NAME OF CEMETERY OR CREMATORY BELLEVILLE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BELLEVILLE, REPUBLIC CO. KANSAS		
24. FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME SILVER SPRING, MD.					25a. DATE REC'D. BY REGISTRAR SEP 10 1986				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 0 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert E. Cox			2a. DATE OF DEATH MONTH DAY YEAR 9 29 86 2b. HOUR 1:30 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 4 1922		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Burtonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15201 Birmingham Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PBX Installer 12b. KIND OF BUSINESS OR INDUSTRY C&P Tel. Co.	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Burtonsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert L. Cox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret J. Edwards		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11	17. INFORMANT ADDRESS 579-18-1533 Virginia M. Cox-wife-(same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Chronic Renal Failure</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>86</u> , to <u>9-29</u> 19 <u>86</u> , that (we) lost saw the deceased alive on <u>9/27</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Michael Berard, MD</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/29/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Berard</u>		22e. ADDRESS <u>7100 Baltimore Ave #401 Coll Pk, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 2, 1986	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Montgomery Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 29 1986
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

00-101-11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

00-18649

1. DECEASED NAME (TYPE OR PRINT) HELEN MAE CRAWFORD <i>Helen Crawford</i>			2a. DATE OF DEATH MONTH 9 DAY 2 YEAR 1986		2b. HOUR 1:30 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH 12 DAY 23 YEAR 00		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? Washington	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO., MD.		
10. CITY OR TOWN OF DEATH Silver Spring, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dr. J. P. Heathcote		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic
13a. STATE D.C.		13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST William MIDDLE Crawford		15. MOTHER'S MAIDEN NAME FIRST Henrietta MIDDLE Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-44-3415		17. INFORMANT 1915 - 18th Street, N.W. Paul R. Crawford (brother) Washington, DC	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 4 YRS.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/7/86 , 19 86 , to 9/2 , 19 86 , that (I) (we) last saw the deceased alive on 9/2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>R. T. Benack</i> DEGREE MD			22c. DATE SIGNED 9/3/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. T. Benack MD		22e. ADDRESS 4115 Colie Dr. Wheaton, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 09/05/86	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE
24. FUNERAL DIRECTOR LATNEY's Funeral Home NAME ADDRESS 3831 Georgia Ave. NW; Washington, DC 20011		25a. DATE REC'D. BY REGISTRAR SEP 18 1986 25b. REGISTRAR'S SIGNATURE	

00-1081-00

FRUIT MORTON 2802

MA 1431117

25

00-19369

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 2 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Grace Cecilia Daly			2a. DATE OF DEATH MONTH DAY YEAR September 18, 1986		2b. HOUR 1:15 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12 16 1914		6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician		12b. KIND OF BUSINESS OR INDUSTRY Census Bureau
13a. STATE Md.			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John J. Daly			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace C. Walsh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578-10-4441		17. INFORMATION ADDRESS 13411 White Church Circle, Germantown, Md. 20874	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/20</u> , 19 <u>86</u> , to <u>9/18</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u> DEGREE				22c. DATESIGNED <u>9/18/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. J. Bennett, MD</u>				22e. ADDRESS <u>4115 Polk Dr. Wheaton</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 20, 86		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md. 20901			
25a. DATE REC'D. BY REGISTRAR SEP 25 1986				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

79

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VICTOR GEORGE DANCAUSE, JR.			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 6 1986			2b. HOUR 6:45 A M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 25 1959		6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW HAMPSHIRE		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17508 Towncrest DRIVE 20877	
14. FATHER'S NAME FIRST MIDDLE LAST VICTOR GEORGE DANCAUSE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1977-1984		17. INFORMANT CONNIE M. DANCAUSE		ADDRESS 17508 Towncrest DRIVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) WIDELY METASTATIC COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 8 , 19 86 , to SEPTEMBER 6 , 19 86 , that (I) (we) last saw the deceased alive on SEPTEMBER 6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward P. Fox				DEGREE M.D.				22c. DATE SIGNED 8 Sept. 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. FOX, LT. MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 10 1986		23c. NAME OF CEMETERY OR CREMATORY Augusta Mem'l Park		23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro, Virginia			
24. FUNERAL DIRECTOR NAME ADDRESS Ives-Pearson F. H. Arlington, Virginia 22201				25a. DATE REC'D. BY REGISTRAR SEP 11 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF NEW YORK	
IN SENATE	
JANUARY 1, 1901	
REPORT	
OF THE	
COMMISSIONERS OF THE LAND OFFICE	
FOR THE YEAR 1900	
ALBANY:	
J. B. LIPPINCOTT & COMPANY, PRINTERS	
1901	

21
00-18539

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST James Morrison Darley						September 12, 1986						2:30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 19 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS 88		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4907 Battery Lane, #203						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cartographer		12b. KIND OF BUSINESS OR INDUSTRY Cartography			
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Beth.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4907 Battery La. # 203		20814			
14. FATHER'S NAME FIRST MIDDLE LAST James Darley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Haig									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I				16b. SOCIAL SECURITY NO. 579-48-8330		17. INFORMANT ADDRESS Richard J. Darley 9406 Ewing Dr. Beth, MD 20817							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 MINUTES 2 WEEKS 20 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: INANITION, DEHYDRATION													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JUNE , 19 86 , to SEPT 12 , 19 86 , that (I) (we) lost saw the deceased alive on SEPT-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Joseph D. Connor MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED SEP 12, 1986					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH D. CONNOR MD				22e. ADDRESS 9420 OLD GEORGETOWN RD Bethesda MD 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/15/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, MD					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016						25a. DATE REC'D. BY REGISTRAR SEP 17 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Penderson					

0-18232

00-19599

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mabel F. Davis</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>September 21, 1986</i>		2b. HOUR <i>2:51 AM</i>						
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 1, 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>94</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Montgomery General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Riggs Bank</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>N.A.</i>			13c. CITY OR TOWN <i>Washington, D.C.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>4442 Garrison St. N.W. 20016</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Levi Streeper Freas</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Menze</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>578-01-7756</i>		17. INFORMANT ADDRESS <i>Jean O'Neil same as # 13</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Esophageal structure - recurrent.</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>months</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 11, 1986</i> to <i>Sept 21, 1986</i> , that (I) (we) last saw the deceased alive on <i>Sept 21, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jeffrey A. Ludmell, M.D.</i> <i>Frederick Moomau, M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9-21-86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frederick Moomau, M.D.</i>						22e. ADDRESS <i>18111 Prince Phillip Dr. Olney, Md. 20832</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Sept. 24, 86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cem.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>SEP 29 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Podesta</i>			

MEDICAL CERTIFICATION

2
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9
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

00-12292

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8626271

1- FOR
STATE
REGISTRAR

REG. NO.

12:32A

1. DECEASED NAME (TYPE OR PRINT) Helen S Dawson			2a. DATE OF DEATH MONTH DAY YEAR 9-12-86			2b. HOUR 12:32A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 10 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 9629 Carriage Road/20895		
14. FATHER'S NAME FIRST MIDDLE LAST John J. Slattery			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Fry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-34-2922		17. INFORMANT ADDRESS Rose Dawson, same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism - left hemisphere</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes; pulmonary fibrosis; broken sacrum</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>9-11-86</u> to <u>9-12-86</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>9-11-86</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did not)</u> view the body after death.									
22b. SIGNATURE <u>Jason Heifer M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-12-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASON HEIFER, M.D.			22e. ADDRESS 838 CAMERON STREET SILVER SPRING, MD 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 15, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS 7557 Wisconsin Ave. Bethesda, MD 20814 PA					25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE <u>Davidson-Rodgers</u>		

BP

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00-18860

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's office must be notified.

BP.

DHMH - 16 60M 7/B4
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BEULAH A. DAY			2a. DATE OF DEATH MONTH DAY YEAR 9 21 86			2b. HOUR 4:20 PM			
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 6 10 92		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO., MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL PRE NATHN CARE CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY Howard		13c. CITY OR TOWN Dayton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4738 Greenbridge Rd 21036	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Warfield					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 820-M-8925		17. INFORMANT ADDRESS Mrs Albert Day 4738 Greenbridge Rd 21036			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hrs 12 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 30, 1985 , to Sept. 21, 1986 , that (I) (we) last saw the deceased alive on Sept. 21, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Raymond Bradshaw, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Bradshaw, M.D.					22e. ADDRESS 345 University Blvd, W Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Providence		23d. LOCATION CITY OR TOWN COUNTY STATE Glenelg, Howard, Maryland		
24. FUNERAL DIRECTOR NAME Harry H Witzke & Family Funeral Home Inc					25. DATE REC'D. BY REGISTRAR SEP 23 1986		25b. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR ADDRESS 4112 Old Columbia Pike Ellicott City									

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 7 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KERMIT W. DAY			2a. DATE OF DEATH MONTH DAY YEAR 09 30 86			2b. HOUR 1737 PM	
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 01 29 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OCCUPATION FOR MOST OF WORKING LIFE) Mgr. Consultant		12b. KIND OF BUSINESS OR INDUSTRY E.P.A.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Day		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera Armstrong		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			
16b. SOCIAL SECURITY NO. 421-09-8446		17. INFORMANT Josephine M. Day same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure / cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1:20 PM Sept 30, 1986 , to 6:00 PM Sept 30, 1986 , that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. John H. Adkins		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Sept 30, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John H. ADKINS		22e. ADDRESS WASHINGTON ADVENTIST HOSPITAL 7600 CARROLL AVE TAKOMA PARK MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 3, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR OCT 06 1986		25b. REGISTRAR'S SIGNATURE [Signature]			
500 University Boulevard West, Silver Spring, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card (page 4) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 7 4
REG. 8626274

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
		Vincent J. DeCola			Sept. 7 '86			4 a. m.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.
Male	White	Feb. 6 1905		81 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
New York	U.S.A.			Montgomery MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg	8904 Edgwood Drive			Barber		Self-Employed		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
Md.		Montgomery	Gaithersburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	8904 Edgwood Dr. (20877)			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		ADDRESS				
Thomas - DeCola		Pasqualine - Cacciadi		8904 Edgwood Dr., Gaithersburg, Md. 20877				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
No		086-28-5322		Theresa Medlar				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PULMONARY EMBOLISM - PHLEBITIS		CIRCULATORY		48 hours				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)		2 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
MYO CARDIAL INFARCTION - NO BLOCK - PHLEBITIS								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-15-83 to 9/4-86, that (I) (we) last saw the deceased alive on 9/4-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
						9/9/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Gregorio Koss, M.D.		#201 15225 Shady Grove Rd., Rockville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		9/10/86		Gate of Heaven Cem.		Silver Spring Montg. Md.		
24. FUNERAL DIRECTOR		316 E. Diamond Ave., Gaithersburg, Md. 20877		25. DATE REC'D BY REGISTRAR				
Roseal Sandison				SEP 15 1986				

25. REGISTRAR'S SIGNATURE: Roseal Sandison

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00-17315

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROY BENJAMIN DEESE			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 2, 1986		2b. HOUR 6:50A M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 7, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FENCE INSTALLER		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED
13a. STATE MARYLAND			13b. COUNTY PRIN. GEO'S ADELPHI	13c. CITY OR TOWN ADELPHI	
14. FATHER'S NAME FIRST MIDDLE LAST GROVER CLEVELAND DEESE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE ANNE LOWERY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 577-24-0484		
17. INFORMANT ROY EARL DEESE SR.			2339 MT. TABOR DR., MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>UNRESECTABLE ESOPHAGEAL CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 2 Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JUNE 26</u> , 19 <u>85</u> , to <u>SEPTEMBER 2</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>SEPTEMBER 2</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE <i>Robert Cameron</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Cameron M.D.		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MD. 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-3-1986	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 8 1986 <i>John Davidson</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copy pages 1 and 2 and should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-15312



22/10/20

X

Post Office
London W.C.2

00-19866

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. DEAR PLEASE, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26276

1. DECEASED NAME (TYPE OR PRINT)			FIRST Florence			MIDDLE Margaret			LAST Delano			2a. DATE KNOWN OF DEATH ESTIMATED 9/30 1986			2b. HOUR 11:25				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1897		6. AGE (IN YEARS) LAST BIRTHDAY 88 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 9/30 1986			2d. HOUR A. M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD							
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4805 Dover Road								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4805 Dover Road/20816					
14. FATHER'S NAME FIRST MIDDLE LAST William -- McMillan								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie -- Higgins											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES) ---				16b. SOCIAL SECURITY NO. 217-36-7056				17. INFORMANT 9808 Laurel St. Willard A. Delano, Fairfax, VA 22032							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>generalized arteriosclerosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a) None																			
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery County, MD				DATE SIGNED 9/30/86							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/3/86				23c. NAME OF CEMETERY OR CREMATORY Fairfax Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax, VA							
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016												25a. DATE REC'D. BY REGISTRAR OCT 03 1986				25b. REGISTRAR'S SIGNATURE			

00-18127

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and signed and sealed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 7 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HECTOR Edmundo R. Delsolar			2a. DATE OF DEATH MONTH DAY YEAR 9-12-86		2b. HOUR 8:55 P _M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 9-6-1908	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHILE	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET-WRITER	12b. KIND OF BUSINESS OR INDUSTRY O.A.S	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE 8605 SPRINGVALE Rd. #25 20910			14. FATHER'S NAME FIRST MIDDLE LAST ENRIQUE A. DEL SOLAR		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMILIA ROSENBERG			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 578-64-5109A			17. INFORMANT ADDRESS 8712 COLESVILLE RD #107 JIMENA S. DEL SOLAR RYAN SILVER SPRING MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA, EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/6, 1986, to 9/12, 1986, that (I) (we) last saw the deceased alive on 9/12, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Penny Bisk		DEGREE MD		DATE SIGNED 9/13/86	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY BISK		22d. ADDRESS 10313 Vergara Ave, Silver Spring, MD			
23a. BURIAL, CREMATION/REMOVAL (SPECIFY) CREMATION	23b. DATE 9-14-1986	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.	23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PGC. Md.	24. FUNERAL DIRECTOR NAME W.W. CHAMBERS Co. INC. ADDRESS 20910 SILVER SPRING, Md.	
25a. DATE REC'D. BY REGISTRAR SEP 16 1986		25b. REGISTRAR'S SIGNATURE			

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including names and dates, but the specific details cannot be discerned.]

0-19961

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 1 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CURTIS E DENNISON			2a. DATE OF DEATH MONTH DAY YEAR 09 29 86			2b. HOUR 3:35 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 03 07		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTEGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpentry		12b. KIND OF BUSINESS OR INDUSTRY Contractor		
13a. STATE MD		13b. COUNTY Washington		13c. CITY OR TOWN DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5638 Utah Ave NW 20015		
14. FATHER'S NAME FIRST MIDDLE LAST Lemuel Dennison			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellenor Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-01-5622		17. INFORMANT Bonnie E Pfizenmayer				ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Status Post thoracic aortic aneurysm resection										
19a. DATE OF OPERATION 9/22/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dissecting thoracic aortic aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 22 , 19 86 , to Sept. 29 , 19 86 that (I) (we) last saw the deceased alive on Sept. 29 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John L. Jones MD					DEGREE MD		22c. DATE SIGNED 9/29/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN L. JONES MD					22e. ADDRESS 7600 Carol Ave, Takoma Park, Md 20908					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4 Oct 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm					ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR OCT 06 1986			
					25b. REGISTRAR'S SIGNATURE John L. Jones					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) ERTLE NASH DENT					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 29 1986		2b. HOUR A M 6:00		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 5 1930		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY Self-employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE NORTH CAROLINA 13b. COUNTY ROBESON 13c. CITY OR TOWN ROWLAND					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT 1, BOX 170 28383		
14. FATHER'S NAME FIRST MIDDLE LAST EUIN N. DENT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Lamb				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1953-1957		17. INFORMANT ADDRESS JOSEPHINE DENT, RT 1, BOX 170, ROWLAND, NC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYCOSIS FUNGOIDES DUE TO, OR AS A CONSEQUENCE OF (b) DIFFUSE HISTIOCYTIC LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 6 , 19 86 , to AUGUST 29 , 19 86 , that (I) (we) lost saw the deceased alive on AUGUST 29 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>D. G. Litaker</i>				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8-29-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. G. LITAKER, LT. MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 1, 1986		23c. NAME OF CEMETERY OR CREMATORY Rayham Bapt Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Robeson Co., N.C.			
24. FUNERAL DIRECTOR NAME Biggs Fun'l Home		801 N. Chestnut Street ADDRESS Lumberton, No. Carolina		25a. DATE REC'D. BY REGISTRAR SEP05 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodatta</i>			

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 8 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert J Dentz			2a. DATE OF DEATH MONTH DAY YEAR 9/27/86		2b. HOUR 12:45 PM
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 11, 1926	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consultant	12b. KIND OF BUSINESS OR INDUSTRY Public Relations	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 15004 Flower Valley Ct. 20853		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Edwin Dentz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. McQuade			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT (Wife) ADDRESS Marjorie Ann Dentz, Court, Rockville, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Primarily DUE TO, OR AS A CONSEQUENCE OF (c) Is unknown					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 1 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 85 9122 85 9127 85			
22a. I certify that (I) (this hospital) attended the deceased from 85 9122 , 19 85 , to 9127 , 19 85 , that (I) (we) last saw the deceased alive on 9127 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE EDWARD L. LEVINE		DEGREE M.D.		22c. DATE SIGNED 9/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD L. LEVINE		22e. ADDRESS 9801 GORDON AVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE October 1, 1986	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. 300 W. Montgomery Ave. Rockville, MD.		25a. DATE REC'D. BY REGISTRAR OCT 03 1986	25b. REGISTRAR'S SIGNATURE		

BP

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Dear", "I", "and", "you" are faintly visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 8 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANToinETTE B. DEPTUCK			2a. DATE OF DEATH MONTH DAY YEAR 9 21 86		2b. HOUR 0729⁴ M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3 14 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE MD			13b. COUNTY MONT	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Scrafin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Veronica Symaczek		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 101-01-3193		17. INFORMANT ADDRESS Linda E. Harper 2843 West Court Grapevine, Texas 76051	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Malignant lymphoma, advanced, large DUE TO, OR AS A CONSEQUENCE OF (c) generalized.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Malnutrition.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/17 , 19 86 , to 9/21 , 19 86 , that (I) (we) last saw the deceased alive on 9/20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ruben Cosca		DEGREE M.D.		22c. DATE SIGNED 9/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN COSCA, M.D.		22e. ADDRESS 17524 REDLAND ROAD BETHWOOD, MARYLAND, 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Sept. 24, 1986	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR SEP 23 1986	25b. REGISTRAR'S SIGNATURE W. J. Harper

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



4
00-18005

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top page (page 1) and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other transmittable event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 6 2 8 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John H Dermody			2a. DATE OF DEATH MONTH DAY YEAR 9 07 86			2b. HOUR 6:30 A.M.	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 17 33		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Va.		7b. CITIZENSHIP OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waiter		12b. KIND OF BUSINESS OR INDUSTRY Hotel	
13a. STATE D.C.		13b. COUNTY Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1221 Mass Ave. #901 94901	
14. FATHER'S NAME FIRST MIDDLE LAST L.A. KNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST M. KNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE NUMBER) 073-28-4044		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b). Arrhythmia, Hypertension DUE TO, OR AS A CONSEQUENCE OF (c). Hypovolemia 2° Massive G.I. bleed APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/5 19 86, to 9/7 19 86, that (I) (we) lost saw the deceased alive on 9/6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael Hill, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/7/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Hill, MD		22e. ADDRESS 1011 N. Capitol St. NW Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-11-86		23c. NAME OF CEMETERY OR CREMATORY Quantic		23d. LOCATION Quantic Co., Va. STATE	
24. FUNERAL DIRECTOR NAME W. H. BACON		ADDRESS 3447-14 St NW		25a. DATE REC'D. BY REGISTRAR 15 1986		25b. REGISTRAR'S SIGNATURE John Paulson	

00-18002



[Faint, mostly illegible handwritten text and markings are visible across the page, including what appears to be a signature at the top and various notes throughout.]

7
00-19798

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	2	6	2	8	3
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Lillian Dezon						2a. DATE OF DEATH MONTH DAY YEAR 9 26 86				2b. HOUR 2400AM						
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR July 25 1928		6 AGE (IN YEARS LAST BIRTHDAY) 58		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD										
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rducator		12b. KIND OF BUSINESS OR INDUSTRY Public School								
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chillum		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 905 Luray Place/20783								
14. FATHER'S NAME FIRST MIDDLE LAST Kade Breeden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Odessa Means												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 579-34-6124		17. INFORMANT ADDRESS Edward Dezon 905 Luray Pl. Chillum, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC EPIDERMAL CARCINOMA OF LEFT LUNG DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 30, 1986, to SEPTEMBER 26, 1986, that (I) (we) last saw the deceased alive on SEPTEMBER 24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										22c. DATE SIGNED 9/26/86						
22b. SIGNATURE James A. Brown MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN MD				22e. ADDRESS 14800 PHYSICIANS LANE #232 ROCKVILLE, MD. 20850												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 30, 1986		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland										
24. FUNERAL DIRECTOR NAME McGuire Funeral Service 7400 Georgia Ave. N.W. Washington, D.C.						25a. DATE OF CERTIFICATE BY REGISTRAR OCT 01 1986				25b. REGISTRAR'S SIGNATURE						

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 60M 7/84
(VRA 15, 4)

17256

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Joseph Dietrich			2a. DATE KNOWN OF DEATH MONTH DAY YEAR HOUR Sept 4 1986 28	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3 8 1914	6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Spr. Md.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4412 Jupiter St		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired
13a. STATE Mont.		13b. CITY OR TOWN Spr.		13c. STREET ADDRESS 4412 Jupiter St
14. FATHER'S NAME FIRST MIDDLE LAST Michael Dietrich		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Keenan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1937-1957 065-14-5963		17. INFORMANT 6440 Trotter Rd. Howard Parlette Clarksville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) _____				19. INTERVAL BETWEEN ONSET AND DEATH 21029
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None				
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Dr. John Rogers		TITLE (SPECIFY) Dep.		DATE SIGNED Sept 4 1986
EXAMINER'S NAME (TYPE OR PRINT) Dr. John Rogers		ADDRESS 1919 Seminary Rd. S.Spr., Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/86	23c. NAME OF CEMETERY OR CREMATORY Linthicum Chapel Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Clarksville Howard Md.				
24. FUNERAL DIRECTOR NAME ADDRESS 7601 Sandy Spring Rd. FLECK Funeral Home Inc. Laurel, Md.		25a. DATE REC'D. BY REGISTRAR SEP 8 1986		25b. REGISTRAR'S SIGNATURE John R. Rendell

Joseph

75

New York

Netted

June

John

Dr. Brown

Marshall

Robert

John Brown

1900



1910 January 10, 1910

Dr. John Brown

John Brown

1910

John

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver this page to the funeral home. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked either "a" or "b", the medical examiner must be notified of the death.

Released by Dr. Mayle
8-20-86
8-20-86
8-20-86

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. HOUR	
Irving		Dolgow		September		20		1986	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Male		Caucasian		03/04/10		76		YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MONTHS	
Russia		USA				Montgomery		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE	
Bethesda		Suburban Hospital		Broker		Real Estate		20852	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Hebrew Home of Gr. Washington	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
William		Jennie		No		146 20 7777		Joanne Dolgow	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		refractory ventricular fibrillation		myocardial ischemia		coronary heart disease		45 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME STREET, FACTORY OFFICE, FARM ETC.)		STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9-20 1986 to 9-20 1986, that (1) (last) saw the deceased alive on 9-20 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Thomas G. Sindereson, MD				9-20-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
THOMAS G. SINDERESON, MD		11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Sept. 23, 1986		Geo. Washington Cemetery		Adelphi, Maryland		STATE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Lives-Pearson Funeral Homes		SEP 24 1986							
NAME		ADDRESS							
Falls Church, Va 22046									



RECEIVED NOV 10 1906

Handwritten notes or signatures, possibly 'W. H. ...' and 'A. ...', running vertically along the right side of the page.

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00-17320

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 8 7

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Stephen V. Dooling		September 3, 1986		8:15 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
MALE	CAUCASIAN	MONTH DAY YEAR	54	MONTGOMERY COUNTY MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Massachusetts	U.S.A.		MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	3501 MONTGOMERY DRIVE	Consultant	Marketing		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND	MONTGOMERY	BETHESDA	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20814 3501 MONTGOMERY DRIVE	
4. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			
Stephen Vincent Dooling	Mae Helen Gallivan	YES			
16b. SOCIAL SECURITY NO.	17. INFORMANT	17. ADDRESS			
1956-1978	Karen M. Dooling	455 Old Town Court Alexandria, VA 22314			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) METASTATIC UNDIFFERENTIATED					5 MONTHS
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA, PRIMARY UNKNOWN					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
NIL					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
NIL	NIL	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-15, 1986, to 09-03, 1986, that (I) (we) last saw the deceased alive on 7-26, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
JEAN VIALLET, M.D.				09-03-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
JEAN VIALLET, ONCOLOGY	BETHESDA NAVAL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Cremation	9-4-86	Metropolitan Crematory	Alexandria, Virginia		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME Richard Rapp, Inc. ADDRESS 1804 T Street, NW, Washington, DC 20009	SEP 8 1986		John Davidson		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



0-17945

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT OSBORNE DORMAN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 9, 1986			2b. HOUR 3:11 A M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 6, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10713 WOODSDALE DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ECONOMIST & STATISTICIAN		12b. KIND OF BUSINESS OR INDUSTRY FED. GOVT.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10713 WOODSDALE DRIVE 20901	
14. FATHER'S NAME FIRST MIDDLE LAST WALTER DORMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE MAILE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-42-5921		17. INFORMANT ADDRESS ELSIE S. DORMAN WIFE SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Histiocytic Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Poly cythemia, arteriosclerotic heart disease, Chronic lung disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)					
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 16, 1980 to September 9, 1986 , that (I) (we) last saw the deceased alive on September 3, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Israel Spector MD				DEGREE MD				22c. DATE SIGNED 9/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Israel Spector MD				22e. ADDRESS 12001 Ferrara Ave. Wheaton Md. 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEP. 11, 1986		23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK FALLS CHURCH		23d. LOCATION CITY OR TOWN COUNTY STATE WHEATON MONTGOMERY VIRGINIA			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.				25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE [Signature]			
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.									

BP

00-18039

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Carroll Maurice Dorsey			2a. DATE OF DEATH MONTH DAY YEAR September 7, 1986		2b. HOUR 9:02am
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR April 26, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS 4 11
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trackman- B.&	12b. KIND OF BUSINESS OR INDUSTRY O. R.R.-Ret.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Frederick	13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Upton Dorsey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Savoy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 710-09-5298	17. INFORMANT ADDRESS Ethel E. Dorsey, Same As #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest & ex pector</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial infarction, PUC, Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/7 9/7
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>MI x 3 CVA</i>					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —	
22a. I certify that (I) (this hospital) attended the deceased from 9/7, 1986, to 9/7, 1986, that (I) (we) lost saw the deceased alive on 9/7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Ethel E. Dorsey</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/7/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur Summers</i>		22e. ADDRESS <i>18111 Prince Philip Dr. Chevy Chase, Md. 20832</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-10-1986	23c. NAME OF CEMETERY OR CREMATOR White Rock		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Charles W. Burrier, Jr., Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Denson-Randall</i>	

MEDICAL CERTIFICATION

9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

<p>1. Name of the person or organization to whom the property is being transferred</p> <p>2. Address of the person or organization to whom the property is being transferred</p> <p>3. City and State of the person or organization to whom the property is being transferred</p> <p>4. Date of the transfer</p> <p>5. Signature of the person or organization to whom the property is being transferred</p>	<p>6. Name of the person or organization from whom the property is being transferred</p> <p>7. Address of the person or organization from whom the property is being transferred</p> <p>8. City and State of the person or organization from whom the property is being transferred</p> <p>9. Date of the transfer</p> <p>10. Signature of the person or organization from whom the property is being transferred</p>	<p>11. Name of the person or organization to whom the property is being transferred</p> <p>12. Address of the person or organization to whom the property is being transferred</p> <p>13. City and State of the person or organization to whom the property is being transferred</p> <p>14. Date of the transfer</p> <p>15. Signature of the person or organization to whom the property is being transferred</p>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please reinsert certificate in pages 1 and 2 and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other trauma, the medical examiner must be notified of this.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 26290	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carolee W Dreyer					2a. DATE OF DEATH MONTH DAY YEAR Sept. 29 1986			2b. HOUR HOURS MIN. 6P M			
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 29 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan N. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN PG 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET ADDRESS / ZIP CODE 630 Sheridan Street 20783						
14. FATHER'S NAME FIRST MIDDLE LAST Archibald White					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lidia Moore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 579 40 1370A		17. INFORMANT 6000 Muncaster Mill Rd. Louis A. Dreyer (Son) Derwood Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Months								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FIRM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from July 29 1986 to Sept. 27 1986 , that (I) (we) lost saw the deceased die on September 4 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not see the body after death.											
22b. SIGNATURE Dr. Benjamin Aravunin					22c. DATE SIGNED 9/30/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Benjamin Aravunin					22e. ADDRESS 18111 Prince Philip Dr. Olney, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/2/86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Md.				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi			11800 New Hampshire Ave. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

(1)

0-17970

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>Virginia Bugg Driver</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>Sept. 7 1986</u>			2b. HOUR <u>11:40 P</u>	
3. SEX <u>F.</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>August 31 1904</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>82</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Book Keeper</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Ins. Company</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <u>1328 Winding Way La. 20902</u>		
13a. STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Wheaton</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Louise Hoskins</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Charles O'Kelly Bugg</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>226-46-8263</u>		17. INFORMANT ADDRESS <u>Charlotte B. Wilder same as #13</u>			
10. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia Right Lung</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____								_____	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Rheumatoid arthritis with severe debility</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I (this hospital) attended the deceased from <u>8-27</u> 19 <u>86</u> , to <u>9-7</u> 19 <u>86</u> , that (I (we) last saw the deceased alive on <u>9-7</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael R. Dobridge</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>9/8/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael R. Dobridge</u>		22e. ADDRESS <u>13975 Ann Ave Silver Spring Md 20904</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Sep. 10, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rehaboth Church Cemetery Boudton</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Mecklenburg Va.</u>			
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins, Jr.</u>		ADDRESS <u>500 University Blvd, West, Silver Spring, Md. 20901</u>		25a. DATE REC'D BY REGISTRAR <u>SEP 15 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>HELEN E DUNLAVEY</u>			2a. DATE OF DEATH MONTH <u>9</u> DAY <u>8</u> YEAR <u>86</u>		2b. HOUR <u>9:40</u> A.M.
3. SEX <u>Female</u>	4. RACE <u>caucasian</u>	5. DATE OF BIRTH MONTH <u>Sept.</u> DAY <u>23</u> YEAR <u>1911</u>		6. AGE (IN YEARS, LAST BIRTHDAY) <u>74</u> YRS.	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.J.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.		
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Key Punch Operat.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Holy Tri. Miss.</u>
13a. STATE <u>Md.</u>			13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Silver Spring</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <u>Thomas</u> MIDDLE <u></u> LAST <u>Farrell</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Ellen</u> MIDDLE <u></u> LAST <u>Higgins</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>086-01-0463</u>	17. INFORMANT <u>Dorothy A. Vukovich</u>		
		ADDRESS <u>4204 Castaway Dr. Rockville, Md. 20853</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANDIDA SEPSIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small Bowel Obstruction</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Renal Failure, ASHD with Cardiac Failure</u>					
19a. DATE OF OPERATION <u>SEPT 8 19 86</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Small Bowel Obstruction</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>SEP 6 19 86</u> to <u>SEPT 8 19 86</u> , that (I) (we) last saw the deceased alive on <u>SEPT 8 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Wendell Cheatham, M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>8 Sept 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WAYMAN WENDELL CHEATHAM, M.D.</u>		22e. ADDRESS <u>7610 Carroll Ave. #230, Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Sept. 11, 86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring Montgomery Md.</u>		23e. DATE REC'D. BY REGISTRAR <u>SEP 15 1986</u>			
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins, Jr.</u>		25. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>			
500 University Blvd West, Silver Spring, Md. 20901					

MEDICAL CERTIFICATION

2
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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or a physician designated in writing by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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Carolina 2000
Small Round Chalkstone

Red Fossil - ASD with Cypripedium
Small Round Chalkstone X

X

and

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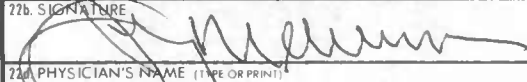
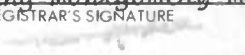
8 Jan 80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 9 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN GILMER DUNN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 14, 1986		2b. HOUR 2:15 P_M					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 6, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chef		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1831 Arcola Avenue 20902	
14. FATHER'S NAME FIRST MIDDLE LAST George Dunn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Berkhead							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-05-6895		17. INFORMANT ADDRESS Margaret D. Scopin Daughter Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 70 to present 19 86 , that (I) (we) last saw the deceased alive on Sept 10 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/15/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Meredino, M.D.			22e. ADDRESS 4701 Randolph Rd. #216 Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE SEP. 18, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR SEP 18 1986		25b. REGISTRAR'S SIGNATURE 					
25c. ADDRESS 500 University Blvd., W. Silver Spring, Md.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and authorized in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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NAME	DATE	OTHER	TIME	SEPT 11, 1955	2:15 P
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951
George	1951	Y	1951	1951	1951

X

John F. Kennedy, Jr.
 200 University Blvd., N. Silver Spring, Md.
 Francis J. Collins, Jr.
 200 University Blvd., N. Silver Spring, Md.
 200 University Blvd., N. Silver Spring, Md.
 200 University Blvd., N. Silver Spring, Md.

00-18451

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 2 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Robert B. Dunn			MONTH DAY YEAR Sept 15 1986			6:45P ^M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	MONTH DAY YEAR Nov. 8 1916		69 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
N. Carolina	U.S.A.			Montgomery MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital			Chief Clerk		Southern Railway		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD			Montgomery		Wheaton		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST William F. Dunn			FIRST MIDDLE LAST Mamie Hancock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
yes			W.W. II		801 30 O'Neill Dr., Apt 2 Gaithersburg, Md. 20877			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUDDEN MASSIVE MYOCARDIAL INFARCT</u>								<u>INSTANTANEOUS</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CORONARY ARTERY DISEASE</u>								<u>YEARS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>WIDESPREAD ATHEROSCLEROSIS</u>								<u>YEARS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
<u>STATUS POST M.I. (SEVERE) X 2; S/P CVA</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 15</u> , 19 <u>86</u> , to <u>SEPT 15</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>FEB</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
<u>Richard P. Delaney</u>								<u>9/16/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
RICHARD P. DELANEY MD			4323 HARVARD ST S.E. 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			Sept. 19, 86		Arlington National		Arlington Arlington Va.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Francis J. Collins, Jr.			SEP 19 1986			<u>John T. Davis</u>		
500 University Blvd. West, Silver Spring, Md.								

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

cleared by Med. Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, absent any injury, or other traumatic event, the medical examiner must be notified at once.

For the purpose of this report, the following information is being provided:

1. The first part of the report is a summary of the work done during the period.

2. The second part of the report is a detailed description of the work done during the period.

3. The third part of the report is a summary of the results of the work done during the period.

4. The fourth part of the report is a summary of the conclusions drawn from the work done during the period.

5. The fifth part of the report is a summary of the recommendations made as a result of the work done during the period.

6. The sixth part of the report is a summary of the work done during the period.

7. The seventh part of the report is a summary of the work done during the period.

8. The eighth part of the report is a summary of the work done during the period.

9. The ninth part of the report is a summary of the work done during the period.

10. The tenth part of the report is a summary of the work done during the period.

11. The eleventh part of the report is a summary of the work done during the period.

12. The twelfth part of the report is a summary of the work done during the period.

13. The thirteenth part of the report is a summary of the work done during the period.

14. The fourteenth part of the report is a summary of the work done during the period.

15. The fifteenth part of the report is a summary of the work done during the period.

16. The sixteenth part of the report is a summary of the work done during the period.

17. The seventeenth part of the report is a summary of the work done during the period.

18. The eighteenth part of the report is a summary of the work done during the period.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RUTH TREIDE DUNNINGTON			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 18, 1986		2b. HOUR 7 A M	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 20, 1901		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2004 Baltimore Road		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		
14. FATHER'S NAME FIRST MIDDLE LAST George Carl Treide		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susannah Winters		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-24-8297		17. INFORMANT ADDRESS Elizabeth W. Simpson 8970 Roll Road Clarence, New York 14031		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Smoking cigarettes and Chronic obstructive Lung Disease</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>85</u> to <u>present</u> 19 <u>86</u> , that (I) <u>last</u> saw the deceased alive on <u>Aug 11</u> 19 <u>86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>viewed</u> (did not) view the body after death.						
22b. SIGNATURE <u>Patricia D. Kellogg</u>				22c. DATE SIGNED <u>9/18/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia D. Kellogg				22e. ADDRESS 809 Viers Mill Road, Rockville, Maryland 20850		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 22 1986		
25b. REGISTRAR'S SIGNATURE		25c. COUNTY Virginia				

12781-1



00619769

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
LEROY		EASTERLING						9 19 '86 0030M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
MALE		Black		8 15 '35		51		0030M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		U. S. A.				Montgomery County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL		Taxi Cab Driver		Private Ind.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
D. C.				Washington				1321 Delafield Place, N. W. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Grant Easterling		Epicasterling		No		578-60-3020		Grant B. Easterling, Brother, Washington, DC 144 Rittenhouse St., NW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Cardiogenic Shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF		(b)		Massive Myocardial Infarction			
		DUE TO, OR AS A CONSEQUENCE OF		(c)		Atherosclerosis			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		Advanced Renal Failure		Polycystic Kidney Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/16/86 to 9/19/86, that (I) (we) last saw the deceased alive on 9/15/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED					
Herman B. Segal MD		Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>		9/20/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		10313 Georgia Ave Silver Spring Md 20902					
Herman B. Segal MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		23 Sep 86		Harmony Memorial Park		Landover, P. G. Co., Maryland			
24. FUNERAL DIRECTOR		1132 You St., NW		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. ERNEST JARVIS CO., INC., Washington, D. C.				SEP 30 1986		John Davidson-Russell			

DDMH - 16 60M 7/84
(VRA 15, 4)

Washington County

Washington, D. C.

Text Can Driver

Washington

D. C.

Washington

Washington

577-1-0430

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0-18750

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 6 2 9 /

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THEODORE E. EATON			2a. DATE OF DEATH MONTH 9 DAY 18 YEAR 86		2b. HOUR 7 ^{AM}
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH NOVEMBER DAY 15 YEAR 1956		6 AGE (IN YEARS LAST BIRTHDAY) 29 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALASKA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY AUTO DEALER
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 15001 ROSECROFT ROAD 20853
14. FATHER'S NAME FIRST KENNETH MIDDLE E. LAST EATON		15. MOTHER'S MAIDEN NAME FIRST PATRICIA MIDDLE ANN LAST BODEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-70-9831		17. INFORMANT ADDRESS KENNETH E. EATON 15001 ROSECROFT ROAD ROCKVILLE, MARYLAND 20853	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 "
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Chronic Renal Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 9, 1986 to Sept 17, 1986 , that (I) (we) lost saw the deceased alive on 9-17-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alison Norris		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-18-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALISON NORRIS		22e. ADDRESS 14805 Physicians Lane Suite 272 Rockville, MD 20855			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS 300 W. Montgomery Ave., Rockville, MD.		25a. DATE REC'D. BY REGISTRAR SEP 22 1986	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.



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WINDY WINTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or checked, the death is due to injury or other traumatic event, the medical attention must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		Hazel Leone Eckhart				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Hazel Leone Eckhart					2a. DATE OF DEATH MONTH DAY YEAR 9/13/86			2b. HOUR 5:55 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 22, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE MARYLAND		13b. COUNTY Mont		13c. CITY OR TOWN Beth.		13e. STREET ADDRESS / ZIP CODE 8600 Irvington Ave. 20817			
14. FATHER'S NAME FIRST MIDDLE LAST Willard J. Bemiss					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy G. Shuman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 369-01-8197		17. INFORMANT ADDRESS Chevy Chase, MD Steven A. Eckhart 4815 De Russey Pkwy					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 86 , to 9/13 , 19 86 , that (I) (we) last saw the deceased alive on 9/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James M. Daniels				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/86		23c. NAME OF CEMETERY OR CREMATORY Arl. Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR SEP 17 1986		25b. REGISTRAR'S SIGNATURE Julia Tidwell-Randall			

Released by Mel Evans, Dr. John F. Tauber 9/16/86

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Page 1



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Page 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 2 6 2 9 9						
1. DECEASED NAME (TYPE OR PRINT) FIRST ANNA MIDDLE LAST EFROSS Anna EFROSS				2a. DATE OF DEATH MONTH DAY YEAR 9/9/86				2b. HOUR 1124PM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH DAY MONTH YEAR JUNE 15 1900		6. AGE (IN YEARS LAST BIRTHDAY) .86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 6121 MONTROSE ROAD 20852										
14. FATHER'S NAME FIRST MIDDLE LAST (UNASCERTAINABLE)				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNASCERTAINABLE)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-10-3892		17. INFORMANT SIDNEY T. EFROSS, 5535 S. BAJA DRIVE, SAN DIEGO, CALIFORNIA				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/9/86 to 9/9/86, that (I) (we) last saw the deceased alive on NEVER 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)										
22b. SIGNATURE Alan Chanalor				DEGREE				22c. DATE SIGNED 9/9/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN CHANALOR				22e. ADDRESS 1525 SHADY GROVE RD ROCKVILLE MD						
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 9/11/1986		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY			23d. LOCATION PRINCE GEORGE'S, MARYLAND		
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 15 1986 Julia Davidson-Randall				

1.

80-19726

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 0 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy O. Ehlers			2a. DATE OF DEATH MONTH DAY YEAR 9-28-86			2b. HOUR 7P M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 29 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MD			13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9804 DAMERON DRIVE 20902	
14. FATHER'S NAME FIRST MIDDLE LAST CLIFTON LEE OSBORN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST INEZ VESTA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 578-26-0841		17. INFORMANT ADDRESS HELEN O. DAY, 9804 DAMERON DR. S.S. MD					
18. CAUSE OF DEATH (Enter only one cause for Part 1. If more than one, list in Part 2.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency & arrest DUETO, OR AS A CONSEQUENCE OF (b) Massive cerebral hemorrhage. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Apoplexion DUETO, OR AS A CONSEQUENCE OF (d) Apoplexion APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2—OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Previous C.V.A.'s.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9-13-86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 9-13-86 Sept. 28 1986					
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body prior death.										
23a. SIGNATURE Miguel A. Rodriguez						DEGREE		23c. DATE SIGNED Sept. 29, 1986		
23b. PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL A. RODRIGUEZ						23d. ADDRESS 831 University Blvd. S. Spring				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE OCT. 1, 1986		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY Washington Md. 20903			
24. FUNERAL DIRECTOR NAME Takoma Funeral Home						25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Oct 2, 1986				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24-86 79

Forme
WASHINGTON DC
U 2 A

FROM: [illegible]
TO: [illegible]
SUBJECT: [illegible]
DATE: [illegible]
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10-22-86

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[illegible]
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00-18035

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86-26301

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		21. MONTH		22. DAY		23. YEAR		24. HOUR	
FREDERICK		P.				ELKIN		9-2-86		19						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE		10. MONTH		11. DAY		12. YEAR	
Male	White	Dec 7 1924		61 YRS.						9-2-86		19				7:58P	
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		14. CITIZEN OF WHAT COUNTRY?		15. MARRIED		16. NEVER MARRIED		17. WIDOWED		18. DIVORCED		19. BALTIMORE CITY OR COUNTY OF DEATH				MD	
New York		USA										Montgomery County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY											
Bethesda		Suburban Hospital		Mail clerk		U S Gov't											
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Rockville		YES <input type="checkbox"/> NO <input type="checkbox"/>		10401 Grosvenor Place								20852	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Nathan		Elkin		Kate		Woelf											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO				Vivian E Klein		Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
912				Aspiration													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last				(b)		mental retardation											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.				hypertensive cardiovascular disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED		9-3-86									
ACTUAL SIGNATURE		Margarita A. Korell, M.D.		ADDRESS		111 Penn Street											
EXAMINER'S NAME (TYPE OR PRINT)																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Cremation		6Sept1986		Cedar Hill Crematory		Suitland		PG		Md							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Robert E. Wilhelm		SEP 10 1986		Julia Anderson-Rudolph													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED-NAME Ida First Middle Last ELSBERG			2a. DATE OF DEATH Month 9 Day 20 Year 86			2b. HOUR 9:50 MIN. P			
3. SEX Female			4. RACE White W			5. DATE OF BIRTH Mar. 5, 1882			
6. AGE (In years last birthday) 104 YRS.			IF UNDER 1 YEAR MONTHS 104 DAYS 104			IF UNDER 24 HRS. HOURS 104 MIN. 104			
7a. BIRTHPLACE (State or foreign country) MD			7b. CITIZEN OF WHAT COUNTRY? USA.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. COUNTY OF DEATH MONTGOMERY Md.			10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hebrew Home of Greater Wash. Home			
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			
13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET AND NUMBER 6121 Montrose Rd. 20853			14. FATHER'S NAME First Middle Last Morris Levy			15. MOTHER'S MAIDEN NAME First Middle Last Rachel (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 579-09-8131			17. INFORMANT Address 20008 Milton Elsbeg 2700 Calvert St. NW Wash., DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ORGANIC BRAIN SX.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			
21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from 9-20 1986 to 9-20 1986 , that (I) (we) last saw the deceased alive on 9-20 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Loretto S. Albion, MD DEGREE MD			
22c. DATE SIGNED 9-21-86			22d. PHYSICIAN'S NAME (Type) LORETO S. ALBION			22e. ADDRESS 6121 MONTROSE RD. Rockville, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 9/22/86			23c. NAME OF CEMETERY OR CREMATORY Wash. Heb. Cong. Mem. Pk.			
23d. LOCATION (City or Town) (County) (State) Wash., DC			24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.			25a. REC'D BY REGISTRAR SEP 24 1986			
25b. REGISTRAR'S SIGNATURE John F. ...			25c. ADDRESS 5130 WI Ave. NW Wash., DC 20016			25d. DATE SEP 24 1986			

00-13071

Hebrew name of hunter slain. (unclear)
Civil War, 1861-1865
Hartford, Conn.

1861-1865
Hartford, Conn.
Civil War, 1861-1865



1861-1865
Hartford, Conn.
Civil War, 1861-1865
Hartford, Conn.

00-18714

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26303

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY Ahern ERONIMOUS			2a. DATE OF DEATH MONTH DAY YEAR 9/14/86		2b. HOUR 9:15 P.	
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR August 15, 1898		
6. AGE (IN YEARS LAST BIRTHDAY) 88		7. UNDER 1 YEAR MONTHS DAYS HOURS YRS		8. UNDER 1 YEAR HOURS DAYS HOURS MIN. YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Manager		
12b. KIND OF BUSINESS OR INDUSTRY Dry Goods		13a. STREET ADDRESS / ZIP CODE 4905 Flower Valley Drive 20853		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Henry Ahern		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Fitzpatrick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 078-09-4675		17. INFORMANT ADDRESS Rita E. Winterbourne same as 13c		
18. CAUSE OF DEATH / Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Distress DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1 day						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (this hospital) attended the deceased from April 83 to Sept 1986 , that (I) (we) lost saw the deceased alive on 9/10/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22a. SIGNATURE Thos G. Ward M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward		22c. ADDRESS 6116 Rockwood, Bethesda 20817		22d. DATE SIGNED 9/15/86		
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 9/19/86		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		
23d. LOCATION Montgomery, New York		23e. STATE STATE		24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		
24. ADDRESS 1331 Rockville Pike, Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-18773

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfonso R. Esposito					2a. DATE OF DEATH MONTH DAY YEAR 9 19 86		2b. HOUR 2 AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Public Acct.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Gesualdo Esposito					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olympia Mosca						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Mary Ann Tucker		ADDRESS 131 Fayton Ave 23503		CITY OR TOWN Norfolk, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Shock (b) Ruptured Aneurysm of Aorta DUE TO, OR AS A CONSEQUENCE OF Ruptured Aneurysm of Aorta (c) Ruptured Aneurysm of Aorta PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure											
19a. DATE OF OPERATION 9.15.86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aortic Aneurysm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8218 Wisconsin Ave - Bethesda 76							
22a. I certify that (I) (this hospital) attended the deceased from 9-15 , 19 86 , to 9-18 , 19 86 , that (I) (we) lost the deceased on 9-18-86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see (saw) body after death.											
22b. SIGNATURE L. Alberto Ninoz, MD					DEGREE MD			22c. DATE SIGNED 9.19.86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Alberto Ninoz, MD					22e. ADDRESS 8218 Wisconsin Ave - Bethesda 76						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey					ADDRESS Funeral Homes PA		25a. DATE REC'D BY REGISTRAR SEP 22 1986				
25b. REGISTRAR'S SIGNATURE [Signature]											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

00-18153

RECEIVED NOTICE NO. 1

00-18811

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers from 1 and 2 and show them to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the hospital doctor must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IRISH R. ETHERSON-FELKER		2a. DATE OF DEATH MONTH DAY YEAR 9 16 86		2b. HOUR 12:15 AM	
3. SEX FEMALE	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 8 17 26		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pres. Ins. Co.		12b. KIND OF BUSINESS OR INDUSTRY Joyner Ins. Co.		13a. STREET ADDRESS / ZIP CODE 3912 Blackburn Road 20903	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST John Lamb		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALESE GARRISON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 11548 February Circle Gary Etherson-son-Apt 202 Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) LEFT VENTRICULAR FAILURE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEVERE TRIPLE VESSEL CORONARY ARTERY DISEASE & CARDIAC ARREST					
19a. DATE OF OPERATION 9/15/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY A. DISEASE - CARDIAC ARREST		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/16 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.			
22b. SIGNATURE J. NEIMAT, MD.		DEGREE		22c. DATE SIGNED 9/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 10313 GEORGIA AV. SILVER SPRING, MD, 20902		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-19-1986		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.		24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home			
25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE J. A. ...			

00-19473

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8626306

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence Cecelia EVANS			2a. DATE OF DEATH MONTH DAY YEAR September 28, 1986		2b. HOUR A. 11:30 M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? American		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 427 Christopher Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 427 Christopher Ave. Apt. 31		20879					
14. FATHER'S NAME FIRST MIDDLE LAST Michael Duffy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Haskins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 199-26-6271		17. INFORMANT Dorothy Price		Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Probable Colonic Carcinoma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/77 to 9/28 , 19 86 , that (I) (we) lost Alan S. Kerner above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN Alan S. Kerner, MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN I. KERNAUER, MD		22e. ADDRESS 10313 GEORGIA AVE S.S. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 1, 1986		23c. NAME OF CEMETERY OR CREMATORY Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Scranton, Penna.	
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR SEP 29 1986			
				25b. REGISTRAR'S SIGNATURE			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

Female
White
Nov. 22, 1902
83
Pennsylvania
American
X
Montgomery County
Gallagher
427 Christopher Avenue
Homestead
10879
Maryland
North
Gallagher X
427 Christopher Ave. Apt. 31
10879
Michael
Bella
Sarah
Washington
192-10-071
Barney Price
Item 13

x xx

00-19795

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2d. HOUR	
Brian Anthony Faber								9 27 19 86		9		27		19		86	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male	Caucasian	Jan. 23, 59		27 YRS.				9 27 19 86		9		27		19		86	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
New York		U.S.				Montgomery County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		Holy Cross Hospital		Geologist		Construction											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Howard		Elkridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5835 Rowanberry Drive									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Jan Willem Hendrik Faber		Margaret Jackson		yes		078-56-7163		Jan Faber		RR#1, POB 396 Springwater, NEW YORK							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
7 8120		Multiple injuries															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		1 XX 9 27 19 86		Driver in auto/auto impact									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		road		Rt. 29 & E. Randolph Rd. S.S. Mont. MD									
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED		9/28/86					
ACTUAL SIGNATURE		M.D. Assistant		MEDICAL EXAMINER		Gregory R. Kauffman, M.D.		ADDRESS		111 Penn St. Balto. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Cremation		9/29/86		Lee's Crematorium		Clinton		Prince Geo. Md.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		Charles F. Bell, Jr. POB 119, Pr. Fred., Md.		OCT 01 1986		Julia Davidson							

00-10582

20% COTTON FIBER

00-18748

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY ELIZABETH FARRELLY			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 16 1986			2b. HOUR 1450		
3. SEX FEMALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 05 04 26 60	6. AGE (IN YEARS) (LAST BIRTHDAY) 60	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 16 1986	2d. HOUR 1450	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.		
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital Patients				12a. USUAL OCCUPATION, NATURE OF WORK FOR MOST OF WORKING LIFE Attorney		12b. KIND OF BUSINESS OR INDUSTRY Hospital
13a. STATE MD			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6413 WINNEPEG RD		20817
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Edward Farrelly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Ann McLean				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 161 22 1252		17. INFORMANT ADDRESS Syracuse, NY 13204 Eugene E. Farrelly, 412 Tennyson Av			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) INDF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. HYPERTENSIVE CARDIOVASCULAR DISEASE								
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 1320 P.M. 9 16 1986		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1320 P.M. 9 16 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED ON FLOOR				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME OF FRIEND		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12813 St. James Way Gaithersburg Mont. 108				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Francis C. Mayle		TITLE (SPECIFY) DEPT		MEDICAL EXAMINER 200 Wisconsin Ave Bethesda Md		DATE SIGNED 9/16/86		
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE		ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Catherine's		23d. LOCATION CITY OR TOWN COUNTY STATE Moscow Lackawanna County Penna.		
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, 7557 Wisconsin Av., Bethesda, Md. 20814				25a. DATE REC'D. BY REGISTRAR SEP-22 1986		25b. REGISTRAR'S SIGNATURE		

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

00-10740

100% COTTON FIBER



00-17941

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. ONLY PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMITTING PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26309									
1. FOR STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS GREGORY FENNEMAN										2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 97 1986		2b. HOUR 4:30P							
3. SEX M		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 12 21 69		6. AGE (IN YEARS LAST BIRTHDAY) 16 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 97 1986		2d. HOUR M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				7. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.							
10. CITY OR TOWN OF DEATH POTOMAC				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13635 GLEN HURST RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT				12b. KIND OF BUSINESS OR INDUSTRY Education							
13a. STATE MD				13b. COUNTY MONTGOMERY				13c. CITY OR TOWN POTOMAC				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 13635 GLEN HURST RD			
14. FATHER'S NAME FIRST MIDDLE LAST Leigh R. Fenneman										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cathleen Doyle									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. n/a				17. INFORMANT ADDRESS Cathleen D. Fenneman, see #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) AUTOEROTIC ACTIVITY DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 97 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HANGING IN BATHROOM											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 13635 GLEN HURST RD POTOMAC MONT MD											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) DEPT M.D.				MEDICAL EXAMINER				DATE SIGNED 9/7/86							
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MOYLE				ADDRESS 8200 WISCONSIN AVE BETHESDA MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept 11, 1986				23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland							
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. 300 W. Montgomery Av., Rockville, Md.										25a. DATE REC'D. BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE [Signature]							

00-1001

DEBIA HOTIOD 6003

DND

W/11-1/2



00-18448

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 6 2 6 3 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY A. MIDDLE LAST Fera			2a. DATE OF DEATH MONTH DAY YEAR 9-17-86		2b. HOUR 1:50 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR December 23, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wheaton Manor Care		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed	12b. KIND OF BUSINESS OR INDUSTRY Grocer	
13a. STATE N/A		13b. COUNTY N/A	13c. CITY OR TOWN Washington, DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		13e. STREET ADDRESS / ZIP CODE 906 Delafield Place, N.W. 20011	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-60-6343		17. INFORMANT ADDRESS Tolanda Trickett Daughter Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 8, 1986, to Sept 17, 1986, that (we) last saw the deceased alive on Sept 17, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bernard A. Fitzgerald MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-17-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD		22e. ADDRESS 217 University Blvd E, Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sep. 20, 1986	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C. 20901		
24. FUNERAL DIRECTOR NAME Francis J. Collins Jr.		25a. DATE REC'D. BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE	
500 University Blvd., W. Silver Spring, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonized pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the registrar must be notified at the time of registration.

34481-00

00-19860

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2d. HOUR	
Gladys Smothermon Finklea								Sept 29 86								A	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Female		Cauc.		1 11 18		68 RS.						Sept. 29, 86				9:50 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Arkansas		United States				Montgomery County MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Gaithersburg		7800 Muncaster Mill Road		Accountant		Hotel											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Montgomery		Gaithersburg				20877									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
John Houston Smothermon		Maud Moore		no		429 38 4041		Jan Ellen Finklea, dau. see #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>John Tauber MD</u>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED Sept. 29, 86											
EXAMINER'S NAME (TYPE OR PRINT)		John Tauber, M.D.		ADDRESS 8218 Wisconsin Avenue Bethesda, Maryland 20814													
23a. BURIAL, CREMATION, REMOVAL (CHECKED)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		Oct. 3, 1986		Gate of Heaven Cemetery		Silver Spring, Maryland											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Robert A. Pumpnrey Funeral Homes, P.A. 300 W. Montgomery Av., Rockville, Md.		OCT 03 1986															

07/B4
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DHMH - 17
(VR A15 ME (5))

00-1000

00-1000

00-19582

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM Earl FISHER				2a. DATE OF DEATH September 24, 1986		2b. HOUR 7:10 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH July DAY 4 YEAR 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Potomac	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9725 Conestoga Way			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive V. Pres. Companies		12b. KIND OF BUSINESS OR U.S. Telephone	
13a. STATE MD	13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9725 Conestoga Way 20854			
14. FATHER'S NAME FIRST Arthur MIDDLE LAST Fisher		15. MOTHER'S MAIDEN NAME FIRST Maude MIDDLE LAST Lewis		16. IF DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II-Korean 498-05-8372			
16a. IF DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 498-05-8372		17. INFORMANT ADDRESS Jean Fisher Same as item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardia-Respiratory Collapse DUE TO, OR AS A CONSEQUENCE OF (b) Brain Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma - lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. One year				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Peripneumatoneuritis - legs							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 17 , 19 86 , to Aug 24 , 19 86 , that (I) (we) lost saw the deceased alive on Aug 17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Azad J. Vosger M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept 25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Azad J. Vosger M.D.		22e. ADDRESS 10000 Falls Rd. Potomac, Md. 20854					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/27/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		23d. LOCATION CITY OR TOWN Rockville, MD COUNTY STATE	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 WI Ave. NW Wash., DC 20016 ADDRESS				25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE J. Davidson	

00-13255

Executive V. Press, Inc.,
2525 Connecticut Ave.
Washington, D.C.

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U.S. GOVERNMENT PRINTING OFFICE: 1967 O - 385-755

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELSA L FLETCHER			2a. DATE OF DEATH MONTH DAY YEAR 9 2 86			2b. HOUR 0645 A		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 4 16 94		
6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.			IF UNDER 1 YEAR MONTHS DAYS 92			IF UNDER 72 HRS. HOURS MIN. 0645 A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER			12b. KIND OF BUSINESS OR INDUSTRY Beauty Salons		
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL			12c. STREET ADDRESS / ZIP CODE 1400 FENWICK LANE APT. 903, 20910		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD.			13c. COUNTY Montgomery			13d. CITY OR TOWN Silver Spring		
13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. FATHER'S NAME FIRST MIDDLE LAST JACOB LILLISH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISA (UNKNOWN)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 153-10-0237			17. INFORMANT ELSA K. CULLER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Cardiorespiratory Arrest IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Septicemia, Adrenal insufficiency, hypothyroidism								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (the hospital) attended the deceased from Aug 5 , 19 86 , to Sept 2 , 19 86 , that (I) (we) last saw the deceased alive on Sept 1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.)			22b. SIGNATURE Thomas J. Locke, MD		
22c. DEGREE MD			22d. ADDRESS 8580 Second Ave. Silver Spring, MD			22e. DATE SIGNED 9/2/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/5/86			23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.			24. FUNERAL DIRECTOR NAME W.W. CHAMBERS, Co.			25a. DATE REC'D. BY REGISTRAR SEP 5 1986		
25b. REGISTRAR'S SIGNATURE John Davidson-Henderson			25c. ADDRESS Silver Spring, MD					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

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00-18443

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 1 4

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALLAN CLAUDE FLOTT			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 14, 1986		2b. HOUR 7:40 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 4, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA	9b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ECONOMIST	12b. KIND OF BUSINESS OR INDUSTRY TRUCKING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE SOUTH CAROLINA 3b. COUNTY HORRY		13c. CITY OR TOWN MYRTLE BEACH	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST STEPHEN FLOTT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VALENTINE M. ROBERTS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11	17. INFORMANT ADDRESS EVELYN S. FLOTT, WIFE SAME			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MINUTES

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) ESOPHAGEAL CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF

(c)

MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 12, 1986</u> to <u>SEPTEMBER 14, 1986</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>SEPTEMBER 14, 1986</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.			
22b. SIGNATURE <i>Mary Pat Dearing MD</i>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED SEPTEMBER 15, 1986
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary Pat Dearing MD</i>	22a. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE SEPTEMBER 17, 1986	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD MARYLAND
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES PA 7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814		25a. DATE REC'D. BY REGISTRAR SEP 19 1986 25b. REGISTRAR'S SIGNATURE <i>Mary Pat Dearing</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-18473



00-17473

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Estelle ESTELLE mm. Francis FRANCIS

2a. DATE OF DEATH MONTH DAY YEAR
9/5/86

2b. HOUR
0450 AM

3. SEX
Female

4. RACE
white

5. DATE OF BIRTH MONTH DAY YEAR
12 5 18

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
67

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD.

10. CITY OR TOWN OF DEATH
Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY
own home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE
MD

13b. COUNTY
Montgomery

13c. CITY OR TOWN
Germantown

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS
14 Neerwinder Ct. 2084

14. FATHER'S NAME FIRST MIDDLE LAST
Ellis G. Wilcher

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Eurilla Webb

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
N/A

16b. SOCIAL SECURITY NO.
577-20-4497

17. INFORMANT ADDRESS
Ellen D. Pulley-sister- Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) STROKE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE TIME BETWEEN ONSET AND DEATH
1 wk

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION
8/29

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
 P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (a) (this hospital) attended the deceased from 8/29 19 86 to 9/5 19 86, that (a) (we) last saw the deceased alive on 9/4 19 86, and that in (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death.

22b. SIGNATURE
Peter Sherer

DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED
9/5/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter Sherer

22e. ADDRESS
3947 Ferrara Dr. Wheaton MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
9-8-1986

23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges Md.

24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home

25a. DATE REC'D. BY REGISTRAR
SEP 9 1986

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages found 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

00-15413

1

20% COTTON

CHILLY



00-19865

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 1 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALMA S. FRANKS			2a. DATE OF DEATH MONTH DAY YEAR Sep. 29, 1986		2b. HOUR 4 ³³ a.m.						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 18, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Flint, Mich.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Montg. Cou. Govt.			
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Jack						15. MOTHER'S MAIDEN NAME Rae		16. STREET ADDRESS / ZIP CODE 11603 Parkedge Drive 20852			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 285-07-2880		17. INFORMANT ADDRESS Lutherville, Md. Denis Franks; 1006 Chestnut Ridge; 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary and Asthma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>7/</u> , to <u>Present</u> , 19 _____, that (I) (we) last saw the deceased alive on <u>April 86</u> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harold C. Sadin, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-29-1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD C. SADIN, M.D.						22e. ADDRESS 2141 K Street N.W., Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-2-1986		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Bedford, Ohio			
24. FUNERAL DIRECTOR NAME Danansky-Goldberg Chapels; 1170 Rockville Pike						25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

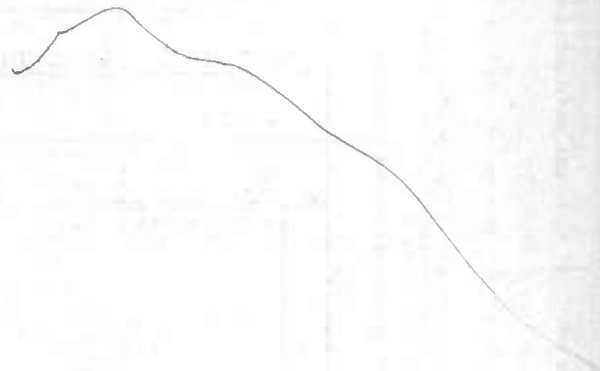
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if called.

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00-19618

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and file them in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8626317 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Gertrude F		Erost		09 14 86		847 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		NOV. 6, 1911		74 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WEST VIRGINIA		U.S.A.				MONTGOMERY CO. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ROCKVILLE		Shady Grove Adventist Hospital		BEAUTICIAN					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
VIRGINIA		ALEXANDRIA		ALEXANDRIA				1807-MT. VERNON AVE. 22301	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
GEORGE H. Cornell		Lena ---- Vogt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		578-09-3436		REV. DR. REICHARD - N.L.H. - ROCKVILLE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AMYOTROPHIC LATERAL SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from APRIL 1984, to SEPT 14 1986, that (I) (we) last saw the deceased alive on SEPT 14 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Thomas E. Dooley, MD						SEPT 14, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Thomas E. Dooley, MD		17904 GEORGETTA AVENUE OLNEY, MARYLAND 20842							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		SEPT. 18/86		CEDAR HILL CEM.		SUITLAND, MARYLAND			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HYSONG CO., INC-1300 N ST., NW WASH.,				SEP 29 1986		Julia Davidson-Randall			

81321-00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 3 1 8			
1. DECEASED NAME (TYPE OR PRINT) Viola Virginia Gault He				20. DATE OF DEATH MONTH DAY YEAR 7 23 86			
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 12 28 19		6. AGE (IN YEARS LAST BIRTHDAY) 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY University	
13a. STATE MD				13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Krausz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Not Known		13d. STREET ADDRESS / ZIP CODE 2010 Drexel Street Apt 201 / 20783			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 123-07-6542		17. INFORMANT D. Gary Gaultette (son)		ADDRESS 18759 Floral Livonia, Michigan	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of the Lung and pleura</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Poss. (Ovarian Carcinoma)</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 3 months 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>S/P Colostomy for Adenocarcinoma of the rectum</u>							
19a. DATE OF OPERATION chest tube 7/21/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pleural Effusion		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19 85</u> to <u>July 22 19 86</u> , that (I) (we) last saw the deceased alive on <u>July 22 19 86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Margery G. Myers</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED July 23, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Margery G. Myers		22e. ADDRESS Family Health Center, PGGH-Mc, Cheverly, MD 20785					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 7-24-86		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25. DATE REC'D BY REGISTRAR AUG 5 1986	
				26. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

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0-20292

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 1 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucile Gill			2a. DATE OF DEATH MONTH DAY YEAR 09-23-86			2b. HOUR 5:45 AM			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 03-19-01		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Mtg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5721 Grovesner Lane 20801	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.				16b. SOCIAL SECURITY NO. 217-03-1757		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF (b) Deambiti Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from May 86 to date 19 86 , that (I) (we) last saw the deceased alive on 9-23-86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE John J. Thorne M.D. 22b. PHYSICIAN'S NAME (TYPE OR PRINT)						22c. DATE SIGNED 9/23/86		22d. ADDRESS 6116 Robinson Bethesda 20817	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 9-26-86		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board					25. DATE REC'D. BY REGISTRAR OCT 6 7 1986		26. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR COLOM 1003

WATER



0-19027

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		MARGARET JONES		LAST GILPIN		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Margaret		Gilpin		9/22/86		6:45 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE		WHITE		JULY 4, 1899		87		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D. C.		USA				Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Brooke Grove Nursing Home				H. Maker		Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		Mont.		Olney		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4201 Briars Road 20832	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
JOSIAH WATERS JONES		MARGARET SHERMAN		NO		215-48-6800		Josiah J. Gilpin Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/15/86 to 9/22/86, that (I) (we) lost saw the deceased alive on 8/15/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
C. H. Ligon MD				9/22/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED					
C. H. Ligon MD		1814 P. Phillips Dr Olney MD 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
CREMATION		SEPT. 23, 1986		BALT./WASH. CREMATORY		LAUREL P. GEORGE MD.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				SEP 23 1986					

75001-0

00-19377

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 2 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mollie W. GLADHILL			2a. DATE OF DEATH MONTH DAY YEAR Sept. 23, 1986			2b. HOUR 7:00P_M					
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 4, 1886		6 AGE (IN YEARS LAST BIRTHDAY) 100 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.					
10. CITY OR TOWN OF DEATH Sandy Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Friends Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9726 Beall Ave. 20872		
14 FATHER'S NAME FIRST MIDDLE LAST Jesse L. Baker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura V. Watkins			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 216-46-0355	
17 INFORMANT Bernard D. Gladhill, Damascus, Md. 20872			17 ADDRESS 1910 Bethesda Church Rd			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1970 to 9.23 , 19 86 , that (I) (we) lost saw the deceased alive on 8.20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M Snow MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/24/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Margaret T. Snow, M.D.						22e. ADDRESS 25800 Ridge Rd., Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Kriders		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster, Carroll, Md.				
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

No	File No.	Name	Address	City	State
10	216-10-355	Howard D. Graham	1910 Webster Drive Dumassons, Mo. 65872	St. Louis	Mo.
		J. Baker	V. Leasing		
		Lease			
		Montgomery Dumassons	9728 Reall Ave. 65872	Sandy Spring	Maryland
		Friends Nursing Home	Horsewife		
		x	Montgomery Co.,		
		White	Ave. B, 1886	100	
		W.	Sept. 23, 1906	7:00	

019-1. Kolesworth, P.A., Lansing, MI.
Sept. 26, 1986
Kubierski
Westland, Michigan, Detroit, MI.

00-19376

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BPH
DHMH - 17
(VR A15 ME (5))

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) David			FIRST Glassman			MIDDLE			LAST			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 9 DAY 18 YEAR 1986			2b HOUR 1245 PM																
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH 11 DAY 10 YEAR 45		6. AGE (IN YEARS) (LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c DATE PRONOUNCED DEAD MONTH 9 DAY 18 YEAR 1986			2d HOUR 1245 PM																
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD																			
10 CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Rep.				12b. KIND OF BUSINESS OR INDUSTRY Aileen Inc.															
13a. STATE Maryland								13b. COUNTY Montgomery				13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 17126 Briardale Road (20855)											
14. FATHER'S NAME FIRST Jacob MIDDLE LAST Glassman								15. MOTHER'S MAIDEN NAME FIRST Hilda MIDDLE LAST Muster								16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) -----								16b. SOCIAL SECURITY NO. 099-43-3220				17. INFORMANT Rockville, Md. 20855 Lori Glassman; 17126 Briardale Road;			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Coronary arteriosclerosis (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																															
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 9-18-86																			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 9/21/86				23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Olney; Montgomery; Maryland																			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR SEP 25 1986				25b. REGISTRAR'S SIGNATURE [Signature]																							

NOTICE

WIND

WIND



WIND

00-20032

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 2 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE PRINT) ALFRED JOSEPH GODIN			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 28, 1986			2b. HOUR 8:24 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 17, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.				
9. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 306 NOTLEY CT.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET.- BARBER		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		
13a. STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 306 NOTLEY CT. 20904	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH GODIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALPHONIC INE BRUSSO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 043-03-0336		17. INFORMANT ADDRESS ADA GODIN (SAME AS ITEM #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary vascular collapse DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) and cerebral arteriosclerosis -								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: life threatening stroke - amputated left leg below knee										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 19 86 to Sept. 19 86 , that (I) (we) last saw the deceased alive on 9/10 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph M. Solinas MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/29/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOSEPH M. SOLINAS			22e. ADDRESS 9801 GEORGIA AVE. SILVER SPRING, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-1-1986		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S R.C. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE DARIEN, FAIRFIELD CO. CONN.			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.					ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR OCT 06 1986		25b. REGISTRAR'S SIGNATURE John T. Anderson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed in this 77 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

00-20035



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the coroner's office must be notified.

00-18600

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 2 6 3 2 4			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
RUTH						GOLDBERG		SEPTEMBER		3,	1986	12:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		OCTOBER 17, 1914		71		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
ILLINOIS		U. S. A.				MONTGOMERY COUNTY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY							
SILVER SPRING		SYLVAN MANOR HEALTH CARE CENTER		HOUSEWIFE		OWN HOME							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE							
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8254 NEW HAMPSHIRE AVENUE		20903			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
(unascertainable)		(unascertainable)		NO		321-09-2282		LEONARD L. LIPSHULTZ,		8630 FENTON STREET,		SILVER SPRING, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)	
				Senile Dementia								10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8/4/86, 1975, to 9/3/86, 19, that (I) (we) lost saw the deceased alive on 8/4/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED									
DR. JEREMY V. COOKE, M. D.		10400 CONNECTICUT AVENUE, KENSINGTON, MARYLAND		9/3/86									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		9/4/1986		KING DAVID MEMORIAL GARDEN		FALLS CHURCH, VIRGINIA							
24a. FUNERAL HOME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE									
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		SEP 09 1986		Julia Gordon-Rudolph									
232 CARROLL STREET, N. W., WASHINGTON, D. C.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 2 5

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IRVIN J. GOLDSTEIN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 30, 1986			2b. HOUR 7:45 AM					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 9 DAY 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND MONTGOMERY SILVER SPRING						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1777 UNIVERSITY BOULEVARD, WEST 20902			
14. FATHER'S NAME FIRST MIDDLE LAST ISRAEL GOLDSTEIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE MONTAS				16. ADDRESS 3905 SWEETBRIAR ROAD WILMINGTON, NORTH CAROLINA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-07-7500		17. INFORMANT ALAN S. GOLDSTEIN, ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>3</u> , 19 <u>86</u> , to <u>August 30</u> , 19 <u>86</u> , that (I) <u>last</u> saw the deceased alive on <u>8/29</u> , 19 <u>86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> view the body after death.											
22b. SIGNATURE <u>G. Lennard Gold, M.D.</u> DR. G. LENNARD GOLD, M. D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. LENNARD GOLD, M. D.						22e. ADDRESS 8630 FENTON STREET SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL			23b. DATE 9/1/1986		23c. NAME OF CEMETERY OR CREMATORY UNITED HEBREW CEMETERY			23d. LOCATION HALETHORPE, BALTIMORE, MARYLAND			
24. FUNERAL HOME NAME ADDRESS DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE SEP 07 1986 <u>Julia Henderson</u>					

BP _____

00-18023

proposed

NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 2 0
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Blanche C. GORDON			2a. DATE OF DEATH MONTH DAY YEAR Sept. 24, 1986		2b. HOUR 5¹² AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Apr. 7, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH Clarksburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2316 Weems Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montg		13c. CITY OR TOWN Clarksburg	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Spencer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Diggs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OF UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 112-20-0400		17. INFORMANT ADDRESS Anthony Gordon (Husband) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, Shock DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes, Cerebrovascular insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Adrenal Insufficiency, Osteoarthritis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Adrenal Insufficiency, Osteoarthritis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR August 19, 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from August 19, 1986 to September 24, 1986 , that (I) (we) last saw the deceased alive on September 19, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Millman, MD		DEGREE MD		22c. DATE SIGNED 9/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Millman, MD		22e. ADDRESS 9711 Medical Center Dr #103 Rockville, Md 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-29-86		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Ijamsville, Fred. MD		24. FUNERAL DIRECTOR NAME George R. Snowden			
25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rodgers			

BP _____

COTTON FIBER



0-17551

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26321

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Gottwals			2a. DATE OF DEATH MONTH DAY YEAR 09/08/86		2b. HOUR 10:20 AM	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 14 03		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC VALLEY NURSING HOME		9. BALTIMORE CITY OR COUNTY OF DEATH MONTELMERY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STREET ADDRESS / ZIP CODE 2844 WISCONSIN AVE NW		13b. CITY OR TOWN WASHINGTON		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MYER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-01-1663		17. INFORMANT HELEN DORRAN ADDRESS 15211 ELK RIDGE WAY S.S. MD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **BASILAR ARTERY OCCLUSION**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Atherosclerosis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**3 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:15 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Mary 19 81 to present 19 86 that (I) (we) lost saw the deceased alive on 6th Sept 19 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harold I. Passes		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD I. PASSES. MD		22e. ADDRESS 3701 MASS. AVE WASH. DC 20016.					

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE SEPT. 1986		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE-WASHINGTON CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL MD	
24. FUNERAL DIRECTOR NAME ADDRESS Taking Funeral Home Inc. 2534 CONN NW DC				25a. DATE REC'D BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 2 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Otis L. Green			2a. DATE OF DEATH MONTH DAY YEAR 9 5 86			2b. HOUR 14 M			
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 6 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS			
7a. BIRTHPLACE (COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN WORKING LIFE) Microbiologist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. STATE md		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Adoniram Green		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie McCarty		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. W.W.II 343-074797		17. INFORMANT ADDRESS Edith Green 2615 Parker Ave., Wheaton, Md. 20902	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated Bowel								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) metastatic prostate cancer									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12, 19 85, to 9/5, 19 86, that (1) (we) last saw the deceased (1) (on 9/4, 19 86, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did not) see the body after death.									
22b. SIGNATURE Peter Sherer			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer			22e. ADDRESS 3947 Fernova Dr. Wheaton md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE Sept. 8, 86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR SEP 9 1986						
500 University Boulevard West, Silver Spring, Md.			25b. REGISTRAR'S SIGNATURE Sheldon Hord						

BP

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RECORDS OF THE
FEDERAL BUREAU OF
INVESTIGATION
AND
THE
DEPARTMENT OF JUSTICE
ARE
MAINTAINED AT THE
FEDERAL BUREAU OF
INVESTIGATION
AND
THE
DEPARTMENT OF JUSTICE
IN
WASHINGTON, D. C.

Handwritten notes and signatures are present in the left margin, including the name "J. Edgar Hoover" and various dates and initials.

08-18053

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FREDA B. GREENSTEIN			2a. DATE OF DEATH MONTH DAY YEAR 8/30/86				2b. HOUR 8:36 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 25, 1907		6. AGE (IN YEARS, LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1401 BLAIR MILL ROAD 20910	
14. FATHER'S NAME FIRST MIDDLE LAST LOU BRODSKY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNASCERTAINABLE) (UNASCERTAINABLE)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 578-16-2647		17. INFORMANT ADDRESS JOSEPH U. GREENSTEIN, 1401 BLAIR MILL ROAD SILVER SPRING, MD.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Perforated diverticulum		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24L. 24L.	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION 8/29/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated diverticulum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/29 , 19 86 , to 8/30 , 19 86 , that (I) (we) last saw the deceased alive on 8/30 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eric A. Oristian				DEGREE M.D.		22c. DATE SIGNED 8/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC A. ORISTIAN, M. D.				22e. ADDRESS 344 UNIVERSITY BOULEVARD, WEST SILVER SPRING, MARYLAND			

23a. BURIAL, CREMATION, REMOVAL (SEE IF 1) BURIAL		23b. DATE 9/1/1986		23c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CONGREGATION CAPITOL PRINCE HEIGHTS GEORGES MARYLAND		23d. LOCATION CITY OR TOWN COUNTY STATE	
23e. NAME OF FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME							
23f. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.				23g. BY REGISTRAR 23h. REGISTRAR'S SIGNATURE SEP 04 1986			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FURNISH OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpanpapers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of choice.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 3 3 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herman Gross			2a. DATE OF DEATH MONTH DAY YEAR 9/5/86		2b. HOUR 5:43 PM
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8/12/96	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant	12b. KIND OF BUSINESS OR INDUSTRY Produce	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN md Montgomery Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rd. 20903 4737 Mt Pisgah 50501	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Gross			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Paris		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W I 579-24-8845	17. INFORMANT ADDRESS Sylvia R. Gross (Same as # 13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiac Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) Heart Block DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Renal Insufficiency					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY REFERRED IN PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 154/86 to 9/5/86, that (I) (we) lost the deceased alive on 9-05-19-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Robert Kramer MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/05/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER		22e. ADDRESS 10313 60 Ave S.C. 876 NO			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/8/1986	23c. NAME OF CEMETERY OR CREMATORY Adas Israel Congregation		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
DONALD DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. RECEIVED BY SEP 10 1986 Julia Benson-Rudner			

BP

[Faint, mostly illegible handwritten text, possibly a list or ledger, with some words like "Name", "Address", and "Occupation" visible.]

00-17949

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 8

2 6 3 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FANNIE NMI GROSSMAN			2a. DATE OF DEATH MONTH DAY YEAR 9 9 1986			2b. HOUR 2 38 AM					
3. SEX FEMALE		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 5 1993		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN			
13a. STATE MARYLAND			13b. CITY OR TOWN MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12325 NEW HAMPSHIRE AVE. 20904		
14. FATHER'S NAME (UNKNOWN)				15. MOTHER'S MAIDEN NAME (UNKNOWN)				16. MALTZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-0176			17. INFORMANT ADDRESS KATHARYN MARKS, 1120 G ST., N.W. #200, WASH., D.C. 20005					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute & Chronic Aspiration Pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/9/86 9/86 1979			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Brain Syndrome, Renal Insufficiency, DTD</u>											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <u>Dr. J. B. Patrick</u> attended the deceased from <u>8/31/79</u> , 19____, to <u>9/9/86</u> , 19____, tho (if we) lost saw the deceased alive on <u>9/6/86</u> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <u>Dr. J. B. Patrick</u> did not view the body after death.											
22b. SIGNATURE J B Patrick MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/9/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick MD						22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 9/10/86		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA			
24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 15 1986 <i>Jane Davidson</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other than 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP



DHMH - 17
(VR A15 ME (5))

1- FOR STATE REGISTRAR		3 DEATH AND MENTAL HYGIENE				2 6 3 3 2	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ZDENKA IRENE GRUBER						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 19 88	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR JULY 23, 1908		6. AGE (IN YEARS) 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CZECHOSLOVAKIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp.				12. USUAL OCCUPATION (TYPE OF WORK) RESEARCH LIBRARIAN	
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD GRUBER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE BREZINOVA		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 578-30-9306		17. INFORMANT ADDRESS JESSIE A. POND, NIECE, 1301 N 97TH ST., OMAHA, NE.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
18a. IMMEDIATE CAUSE (a) 9248 Cardiac Pulmonary Arrest		18b. DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock		18c. DUE TO, OR AS A CONSEQUENCE OF (c) Burns		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 6 19 88		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Burned by Space Heater			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Silver Crest Dr. Damascus North Md			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE [Signature]		TITLE (SPECIFY) D. O. P. MEDICAL EXAMINER				DATE SIGNED 8/19/88	
EXAMINER'S NAME (TYPE OR PRINT) JOHN ROGERS, M.D.		ADDRESS SEMINARY ROAD, SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 9/9/86		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SUILAND PG MD.	
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. ADDRESS 1804 T ST., N.W., WASHINGTON, D.C. 20009				25a. DATE REC'D. BY REGISTRAR SEP 11 1986		25b. REGISTRAR'S SIGNATURE [Signature]	



LEWIS & CLARK

REGISTERED

00-17802

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 3 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIRGINIA H. HALBERT			2a. DATE OF DEATH MONTH 9 DAY 10 YEAR 86			2b. HOUR 8:30 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 18 YEAR 92		6. AGE (IN YEARS (LAST BIRTHDAY)) 94 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 72 HRS. HOURS 0 MIN. 0	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carmage Hill				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Conn.				13b. COUNTY New London		13c. CITY OR TOWN New London		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 184 Gardner Ave., 06320	
14. FATHER'S NAME FIRST Frederick MIDDLE William LAST LaForge				15. MOTHER'S MAIDEN NAME FIRST Eleanor MIDDLE Ruth LAST Knowles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 047-38-6147		17. INFORMANT (niece) ADDRESS Mrs. James F. Kinsella- 12301 LaPlata St. Sil, Spr, Md. 20904					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive cardiovascular d.										years	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Chronic atrial fibrillation - Dehydration + nutritional anemia - Organic brain syndrome											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 8/11 , 19 86 , to 9/10 , 19 86 that (1) (we) last saw the deceased alive on 8/28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James R. Coleman MD						DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. COLEMAN						22e. ADDRESS 3929 FERRARA DRIVE WHEATON MARYLAND 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9-11-1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria COUNTY Virginia STATE Virginia				
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home						ADDRESS 11800 N.H. Ave., Sil. Spr, Md.		25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

00-11809

RECEIVED BY THE
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

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DHMH - 17
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(VR A15 ME (3))

1- FORMed. Ex., 10/1/86/ G-620, DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
86		Andrew		Alan		Hall		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 7 19 86		2b. HOUR 11:19 a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1956		6. AGE (IN YEARS) 29 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		8. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		9. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 7 19 86	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1005 Aster Blvd. 20850			
14. FATHER'S NAME FIRST MIDDLE LAST Rogers E. Hall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernetta E. Flory									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-68-1600		17. INFORMANT Rogers E. Hall same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Phencyclidine Intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR PRIMARY CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9 3 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject used Phencyclidine							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Viers Mill Rd., Rockville, Mont., Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 9/8/86	
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.		ADDRESS 111 Penn St. Balto. MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/10/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR SEP 15 1986				25b. REGISTRAR'S SIGNATURE [Signature]			

NOTICE

NOTICE

00-19375

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained - within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pearl C. Hall			2a. DATE OF DEATH MONTH DAY YEAR September 20, 1986			2b. HOUR 12 MIDNITE M				
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH March 13, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Accounting		
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #1141 20902 1131 University Blvd. West		
14. FATHER'S NAME FIRST MIDDLE LAST James Collins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice McNew			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				
16b. SOCIAL SECURITY NO. 233-09-6018			17. INFORMANT 5027 36th Place, Hyattsville William E. Hall Maryland, 20782							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RECENT MYOCARDIAL INFARCTION and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRAL EMBOLIC STROKE - RIGHT HEMISPHERE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Exogenous obesity -</u>										
19a. DATE OF OPERATION 9/05			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/05 1986 to 9/20 1986, that (I) (we) last saw the deceased alive on 9/19 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph M. Solinas MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/20/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH M. SOLINAS MD			22e. ADDRESS 9801 GEORGIA AV. S.S. Md 20902							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 22, 1986			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Georges Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd., West, Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE		

BP

DHMH - 16 60M 7/B4

(VRA 15, 4)

00-174621

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edythe H. Hamlin			2a. DATE OF DEATH MONTH DAY YEAR Sept. 2 1986		2b. HOUR 10:40pm
3 SEX F	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 16 1891		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Health Care Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife		13a. STREET ADDRESS / ZIP CODE 10219 Big Rock Rd 20901	
13b. COUNTY Md.		13c. CITY OR TOWN Montgomery Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Powhatan Hoback		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cynthia Harless		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 558-34-2237		17. INFORMANT June H. Burke Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke - right hemiparesis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerotic DUE TO, OR AS A CONSEQUENCE OF (c) Many years	

MEDICAL CERTIFICATION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 28 1986, to September 2 1986, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bennet A. Porter Jr. M.D.				DEGREE M.D.		22c. DATE SIGNED Sept. 3, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bennet A. Porter Jr. M.D.				22e. ADDRESS 9301 Coleridge Rd, Silver Spring, Md. 20901			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 6, 86		23c. NAME OF CEMETERY OR CREMATORY Salem Baptist Cemetery California Missouri		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Francis J. Collins Jr. 500 University Blvd. W. Silver Spring Md 20901				25a. DATE REC'D BY REGISTRAR SEP 9 1986		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please reattach pages 3 and 4 to the certificate. Pages 3 and 4 should be held until 72 hours after death. If the medical examiner must be notified at any time, the medical examiner must be notified at any time.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at any time.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR Josephine K. Hammer					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Josephine K Hammer					2a. DATE OF DEATH MONTH Sept DAY 3 YEAR 86 2b. HOUR 2 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 21 YEAR 93		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH SILVERSPRINGS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SYLVAN MANOR Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator-US		12b. KIND OF BUSINESS OR INDUSTRY Pub. Health	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Washington, DC		13b. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3302 24th St. NE 28098			
14. FATHER'S NAME FIRST Victor MIDDLE Kuntz LAST Kuntz					15. MOTHER'S MAIDEN NAME FIRST Barbara MIDDLE Anna LAST Herring				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 66 6807		17. INFORMANT ADDRESS Wash., DC John A. Bowman 2900 Newton St. NE 20018					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAY 6 1986 to SEPT 3 1986 , that I (we) last saw the deceased alive on SEPT 2 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Walter E. Goode DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3 SEPT 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOODE MD					22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/5/86		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park Cem.		23d. LOCATION CITY OR TOWN Falls Church, VA COUNTY STATE			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 WI Ave. NW Wash., DC 20016 ADDRESS					25a. DATE REC'D. BY REGISTRAR SEP 9 1986		25b. REGISTRAR'S SIGNATURE		

0-15110



00-17521

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR Nancy Parsons Hancock					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) NANCY Parsons HANCOCK					2a. DATE OF DEATH MONTH DAY YEAR Sept 5 1986			2b. HOUR MIN. 11:21 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 7, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. CITY OR TOWN Mont.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 8101 CT Ave. S 307 20815			
14. FATHER'S NAME FIRST MIDDLE LAST Jack Haas					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Taggart				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-38-5812		17. INFORMANT ADDRESS Robert W. Hancock Same as item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, OR NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Congestive heart failure, pulmonary edema									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-4-1986 to 9-5-1986 , that (I) (we) last saw the deceased alive on 9-5-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen W. DeJeter, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-6-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEJETER, M.D.				22e. ADDRESS 6719 WILSON LANE, BETHESDA, MD. 20817					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/8/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE Nancy Parsons Hancock			

BP

15271-00

00-18125

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) STEPHEN HARNESBERGER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 14, 1986		2b. HOUR 4:40A M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR MARCH, 02, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 14205 Oakvale St. 20853
14. FATHER'S NAME FIRST MIDDLE LAST Robert Samuel Harnesberger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Ivey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 579-12-9733		17. INFORMANT ADDRESS Adelaide I. Harnesberger, Item 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **MYOCARDIAL ACUTE INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **PULMONARY EDEMA**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 hours

5 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

PREVIOUS MYOCARDIAL INFARCTION, DIABETES mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> , 19 <u>86</u> , to <u>9-14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-14</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE C. Feinstein MD	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9, 14 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. FEINSTEIN MD		22e. ADDRESS 18111 PRINCE PHILIP Dr. OLNEY Md 20832	

MEDICAL CERTIFICATION

Coroner notified and released

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 16, 1986	23c. NAME OF CEMETERY OR CREMATORY Pine Grove	23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Carroll, Md.
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 16 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other" in the cause of death, the medical examiner must be notified of the cause of death.

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Section 2.1

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Rockville Montgomery Maryland

Robert Samuel Barnett

Abbildung 3.1: Histogramm der Häufigkeiten der Anzahl der Kinder pro Familie

EE72-51-272 S W 20Y

Sept. 16, 1986 Pine Grove Mr. A. J. (Barry) M.

John E. Moleworthy, Jr., Treasurer

2
00-193731- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 6 3 4 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank I. Harris			2a. DATE OF DEATH MONTH DAY YEAR September 21 1986		2b. HOUR 2:55P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR September 9, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor	12b. KIND OF BUSINESS OR INDUSTRY Navy
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					
13b. COUNTY Montgomery					
13c. CITY OR TOWN Silver Spring					
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
13e. STREET ADDRESS / ZIP CODE 3642 Gleneagles Drive 20906					
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Harris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1918		17. INFORMANT ADDRESS Margie W. Harris same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6d+ys</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/11</u> , 19 <u>77</u> , to <u>21 Sep</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>20 Sep</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Gustavo S. Belaval</u>				22c. DATE SIGNED 22 Sep 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gustavo S. Belaval				22e. ADDRESS Leisure World Medical Ctr. Silver Spring, MD 20906	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 23, 86		23c. NAME OF CEMETERY OR CREMATORY Parklawn	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.		24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md.			
25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified of and

BP _____



00-19475

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "X", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR RANDALL M.					8 6 2 6 3 4 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) RANDALL M. HARRIS					2a. DATE OF DEATH MONTH DAY YEAR 09-26-86				
2. SEX MALE					2b. HOUR 0630 M				
3. RACE WHITE					3. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.				
4. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.					5. BIRTH MONTH DAY YEAR 06 24 14				
6. CITIZEN OF WHAT COUNTRY? USA					7. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
8. CITY OR TOWN OF DEATH Rockville					9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADV. HOSPITAL				
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSTALLER				
12a. STATE MD.					12b. CITY OR TOWN DAMASCUS				
13a. COUNTY MONTGOMERY					13b. STREET ADDRESS 25024 OAK DRIVE 20872				
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM EARL HARRIS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FAYE MARIE DIXON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 577-07-2767				
17. INFORMANT 4844S FIRST ST. SOUTH					18. EDNA PAULINE PASCOE ARLINGTON, VA. 22204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Jaundice Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Anemia									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 10 1986 to Sept 26 1986 , that (I) (we) lost saw the deceased alive on Sept 26 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) alter the body after death.									
22b. SIGNATURE [Signature]					DEGREE MD		22c. DATE SIGNED 9/29/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. K. Kim					22e. ADDRESS 8921 Shady Grove Ct				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE SEPT. 27, 1986		23c. NAME OF CEMETERY OR CREMATORY BALT. WASH. CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL P. GEORGE MD.		
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879					25a. DATE REC'D BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

27421-00

00-18634

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 4 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELSIE D HARSCH			2a. DATE OF DEATH MONTH DAY YEAR 9 10 86			2b. HOUR 7.45 ^P _M						
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 30 99		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS				12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) Medical Secretary		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1316 Fenwick Lane 20910			
14. FATHER'S NAME FIRST MIDDLE LAST George Lee Drury				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Cruik								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 578-48-5524		17. INFORMANT Gordon Harsch			ADDRESS same as 13				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Hepatic failure**

DUE TO, OR AS A CONSEQUENCE OF

(b) **metastatic liver disease**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Cancer of the Colon**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from Aug 15 , 19 86 , to Sept 10 , 19 86 , that (I) (we) saw the deceased alive on 9-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Edward Richards M.D.				DEGREE M.D.		22c. DATE SIGNED 9-11-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Richards M.D.				22e. ADDRESS 10301 Georgia Ave., Silver Spring, Md. 20902			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 13, 86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR SEP 18 1986		25b. REGISTRAR'S SIGNATURE [Signature]	
500 University Blvd. West, Silver Spring, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the cause of death must be certified by a physician.



300 COTTON - 20000

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Handwritten text, possibly a signature or a date, located in the upper left corner of the page.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 4 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paul		MIDDLE N		LAST HARTMAN		DATE OF DEATH MONTH September DAY 22 YEAR 1982		7b HOUR 6:19 AM	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH Feb. DAY 22 YEAR 1913		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8504 Howell Road/20817	
14. FATHER'S NAME FIRST Richard MIDDLE T. LAST Oettel				15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Dieudonne LAST Dieudonne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Mary Ruth Hartman, same as #13		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremic Shock								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured Aortic aneurysm with days	
								DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple myeloma with bone lesions									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 9/15 , 19 86 , to 7/20 , 19 86 , that (I) (the hospital) saw the deceased alive on 9/19 , 19 86 , and that in (my) (the hospital's) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) (did not) view the body after death.									
22b. SIGNATURE Stephen J. Newman DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman, M.D.				22e. ADDRESS 11500 Old Georgetown Road Rockville, Maryland 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Sept. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum		23d. LOCATION CITY OR TOWN Brentwood, Maryland COUNTY Dorchester STATE Maryland			
24. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey Funeral Homes				25a. DATE REC'D BY REG. OFF. PA SEP 22 1986 25b. REGISTRAR'S SIGNATURE					
24. FUNERAL DIRECTOR'S ADDRESS 7557 Wisconsin Ave. Bethesda, MD 20814									

MEDICAL CERTIFICATION

2662

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 4 4

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna Augusta Harvey			2a. DATE OF DEATH MONTH DAY YEAR September 12, 1986		2b. HOUR 7:00A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3-21-04	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Sandy Spring	
13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS / ZIP CODE 17310 Quaker Lane #C-16 20860			
14. FATHER'S NAME FIRST MIDDLE LAST William Arnold Ray			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Case			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT (son) Charles E. Harvey- 238 Harland Road Revere Beach, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 9-12-1986, to 9-12-1986, that (we) last saw the deceased alive on 9-12-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-12-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ROTSZMAN		22e. ADDRESS 10401 Old Georgetown Rd #204 Bethesda, Md 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-1986		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtontsville Montgomery Md.
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 15 1986		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and necessary medical papers filed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic, event, a medical examiner must be notified at once.

Cleared by John S. Rogers, M.D.
9-12-86

00-1-803

00-19596

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Caroline Mary Hauff			2a. DATE OF DEATH MONTH DAY YEAR 9 23 86		2b. HOUR 1:22 PM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 15 11		
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 72 HRS.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
11. CITY OR TOWN OF DEATH Takoma Park		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		13. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE md		14b. CITY OR TOWN Anne Arundel Lothian		14c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
15. FATHER'S NAME FIRST MIDDLE LAST Anthony Chwalek		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Stawchek		17. ADDRESS Lot 200 Lyons Creek Mobile Estate		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 197-24-1897		19. INFORMANT Husband Harold E. Hauff		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver metastases DUE TO, OR AS A CONSEQUENCE OF (b) Colon Cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 3 yrs		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Bone + lung mets				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6/83, 19, to 9/86, 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Peter Sherer MD		22c. DATE SIGNED 9-23-86		
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD		23b. ADDRESS 3947 Ferrara Dr. Wheaton md 20906				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep. 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR SEP 29 1986		
25b. REGISTRAR'S SIGNATURE John Davidson						

BP



RECEIVED
JAN 10 1964

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "RECEIVED" and "JAN 10 1964" are visible.]

00-18355

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rita Agnes Healey			2a. DATE OF DEATH MONTH DAY YEAR Sept. 14, 1986		2b. HOUR 6:00 p.m.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 3, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Damascus	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10304 Bloom Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Sears	
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? NO	13e. STREET ADDRESS / ZIP CODE 383 Westside Dr. 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Charles McLucas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ama Ryan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 172-26-7750		17. INFORMANT 10304 Bloom Dr. Damascus, Md. Kathy Proctor (daugh) 20872		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/8 19 86 to 9 19 86 that (I) (we) last saw the deceased alive on 8/8 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Eugene P. Libre				DEGREE MD		22c. DATE SIGNED 9/15/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Libre				22e. ADDRESS 10400 Connecticut Ave. Kensington, Md. 20895		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/15/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR SEP 19 1986		
1331 Rockville Pike Rockville, Md. 20852				25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-18322

0-19458

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Richard L Heilman		2a. DATE OF DEATH MONTH DAY YEAR 9/26/86		2b. HOUR 2:59 PM
3. SEX M	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 11 26 11		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH mont. MD.
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. STATE Md.	13b. COUNTY mont.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2016 Park Hill Drive 20910
14. FATHER'S NAME FIRST MIDDLE LAST Louis I Heilman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nola J. Barrow		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. 645 24 5137		17. INFORMANT Same as DR 13E John G. Chappell (Bro. in Law)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASPIRATION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days 1 month 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Had abdominal aneurysm resection</u>			
19a. DATE OF OPERATION 7/27/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL AORTIC ANEURYSM	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1; OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27/86</u> to <u>9/25/86</u> that (I) (we) last saw the deceased alive on <u>9/25/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Garry D. Ruben</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/27/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARRY D. RUBEN, M.D.		22e. ADDRESS 11120 New Hamp Ave. Silver Spring, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 9/27/86	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Service Alexandria, Va.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Hines/Rinaldi S.S. Md.		25a. DATE REC'D. BY REGISTRAR SEP 29 1986	25b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 13-16-17-23- film G 619
FOR 9-23-86 I.J.
STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harry H. Hendricks			2a. DATE OF DEATH MONTH DAY YEAR September 11, 1986		2b. HOUR 12:20pm
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 12, 1897	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	12b. KIND OF BUSINESS OR INDUSTRY Admin. Farm Credit		
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Hendricks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) World War II 1213 38 2872		17. INFORMANT ADDRESS Bethesda, Md 20817 Nancy Law (daughter) 9215 Laurel Oak Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of Lung with DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases to bone. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/8/27 to 9/11/86, that (I) saw the deceased alive on 9/6/86 and that (I) signed the death certificate on 9/11/86. I am a physician and my opinion of death occurred on the date and hour and from the causes stated above. (If not a physician, delete the above sentence.)					
22b. SIGNATURE J. Blaine Fitzgerald, M.D.				22c. DATE SIGNED Sept. 11, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.				22e. ADDRESS 8218 Wisconsin Avenue Bethesda, Maryland 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 Sept. 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 15 1986	
				25b. REGISTRAR'S SIGNATURE J. Blaine Fitzgerald	

BP

0-15254

15
00-19010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26347
REG. NO.

1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH ESTI-MATED										21. HOUR	
1. DECEASED NAME (TYPE OR PRINT)										20. DATE KNOWN OF DEATH ESTI-MATED										21. HOUR	
Walter A. Hereth										Sept 14 1986										1043 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		24. HOUR							
m		W		March 28 1968		68 YRS.		MONTHS		DAYS		Sept 14 1986		1043 AM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
New York				U.S.								Montgomery MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring				General Hosp				Engineer				Nat'l Secur-									
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?									
MD				Howard				Baltimore				YES <input type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET ADDRESS				21797									
Walter Henry Hereth				Marguerite Haemer				2551 Florence Rd				ity									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
No				116-03-0306				Mrs. Sibbald Hereth - Same as #13													

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Acute myocardial Dis</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) <u></u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u></u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
<u>None</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
<u>None</u>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.						TITLE (SPECIFY)			DATE SIGNED <u>Sept 14 1986</u>				
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Removal				9-18-86									
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE	
Anatomy Board						SEP 23 1986						<u>John S. Rogers</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00-10010

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20-000000-002

0-17332

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 5 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Octavis L. Hewlin, Jr Octavis L. Hewlin Jr			2a. DATE OF DEATH MONTH DAY YEAR September 3, 1986		2b. HOUR A M 5:30 A		
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR March 26, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Cashier	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE DC				13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Octavis Hewlin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Silver			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 242-58-7743		17. INFORMANT ADDRESS Louise Hewlin, 7824 Sheriff Road, Landover, MD 20785			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asphyxia, fracture DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) motor vehicle DUE TO, OR AS A CONSEQUENCE OF (c) motor vehicle crash APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): emphysema, chronic cough							
19a. DATE OF OPERATION 2/10/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: lung cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from February 10, 1986 to September 3, 1986 , that (I) (we) lost saw the deceased alive on September 3, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lewis Hilliard Dennis				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Hilliard Dennis, M.D.				22e. ADDRESS 831 University Blvd, Silver Spring, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-6-86		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Richard Rapp, Inc. 1804 T Street, NW, Washington, DC 20009				25a. DATE REC'D. BY REGISTRAR SEP 8 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers	

10-17393

2002 OCTOBER 18

THIRTY-THREE

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Black", "White", and "County" are faintly visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 3 5 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOEL HILER		2a. DATE OF DEATH MONTH DAY YEAR 9 13 86		2b. HOUR 4:15 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 22, 1918	
6. AGE (IN YEARS LAST BIRTHDAY) 67		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker	
12b. KIND OF BUSINESS OR INDUSTRY Merchant		13a. STREET ADDRESS / ZIP CODE 1118 Loxford Terrace 20901		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Solomon Nudel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Hiler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 577-46-1581		17. INFORMANT Esther Hiler (Same as # 13)		ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5d

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 7 , 19 87 , to Sept 13 , 19 86 , that (I) (we) lost saw the deceased alive on Sept 13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael A. Lincoln MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL LINCOLN MD				22e. ADDRESS 10313 George Washington Silver Spring Md 20902			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/14/1986		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24. DONOR OF ORGAN DONOR OF TISSUE DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR SEP 17 1986			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				25c. REGISTRAR'S SIGNATURE			

0-18872

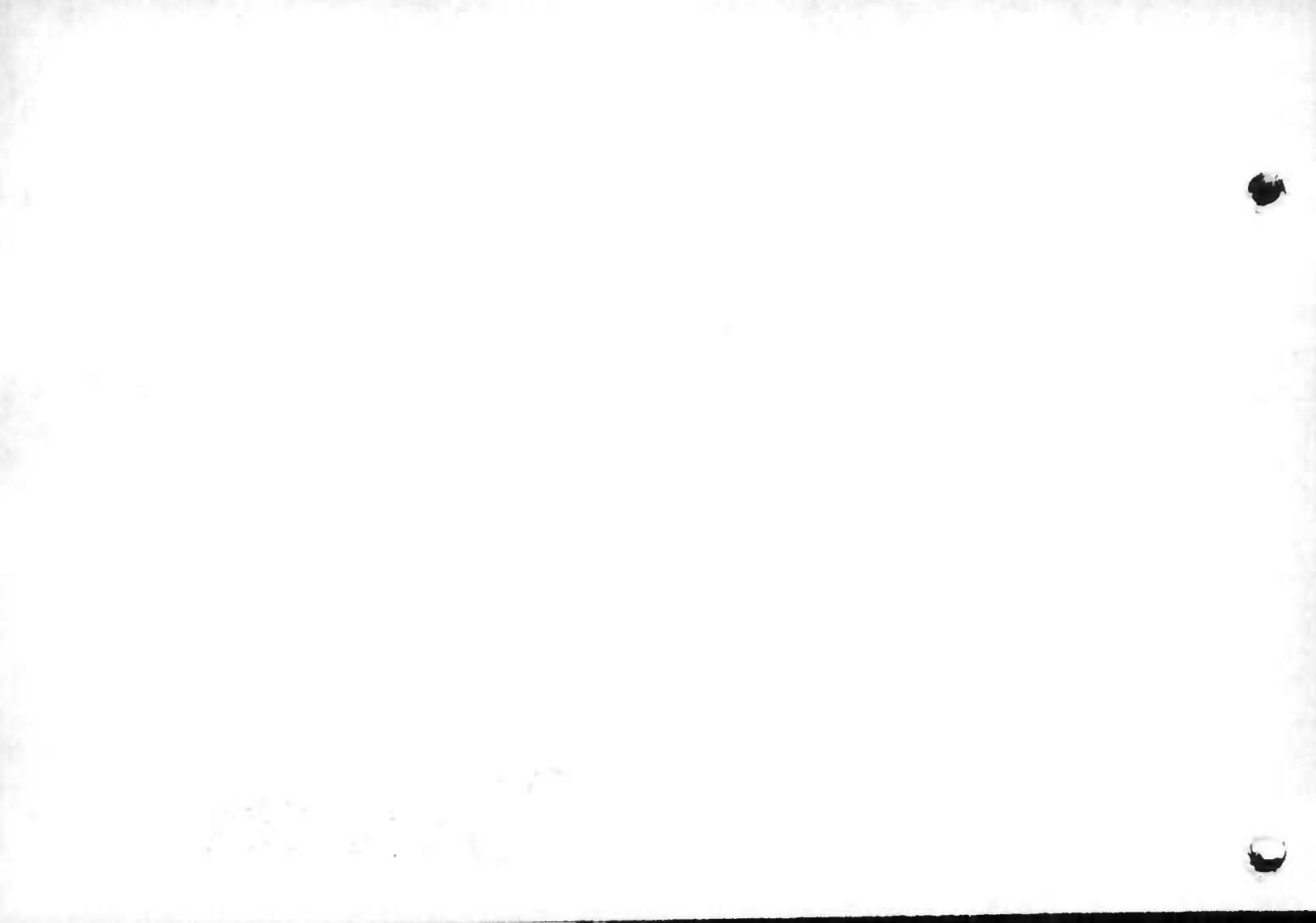
2

1

SEP 14 1966

VOID

CERTIFICATE # 86-26352



3
00-18083

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR					
Maurine Claire Hoag						8/19			19	86							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR					
Female	White	Aug. 12, 1908	78 YRS.			8/19			19	86		8:30 P. M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD								
Iowa		U.S.A.				Montgomery County											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Silver Spring			Holy Cross Hospital			Beauty Shop Operator			Private								
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			20853									
Maryland		Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	15520 Georgia Ave.												
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
Clayton E. Conger			Mona Dale Arnold														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Husband)			ADDRESS								
N/A			N/A			217- 74- 1431			Mr. Merald E. Hoag 15520 Georgia Ave. Silver Spring, M.D.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>carcinoma of the gall bladder.</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
None																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
None										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
								None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
John S. Rogers, M.D.				M.D. Deputy				8/21/86									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				1919 Seminary Road				Silver Spring, Montgomery County, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY		STATE	
Cremation				8-21-86		Lee's Crematory				Washington, D.C. 20002							
24. FUNERAL DIRECTOR NAME J. William Lee; s Sons Company												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
300 4th Street; N.E. Washington, D.C. 20002.												SEP 05 1986		Julia Denson-Rodden			

00-10083

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 5 4

1- FOR
STATE
REGISTRAR

REG. NO.

00-18444

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Dorothy Jane Hoesch

2a. DATE OF DEATH MONTH DAY YEAR
September 16, 1986

2b. HOUR
3:05PM

3. SEX
Female

4. RACE
Caucasian

5. DATE OF BIRTH MONTH DAY YEAR
May 14, 1901

6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wisconsin

7b. CITIZEN OF WHAT COUNTRY?
United States

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD.

10. CITY OR TOWN OF DEATH
Chevy Chase

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Retirement & Nursing Ctr.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY
Own Home

13a. STATE
Maryland

13b. COUNTY
Montgomery

13c. CITY OR TOWN
Bethesda

13d. INSIDE CITY LIMITS?
YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE
5313 Wapakoneta Road 20816

14. FATHER'S NAME FIRST MIDDLE LAST
Thomas Abraham

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Louise Keitel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
379-26-3610

17. INFORMANT daughter ADDRESS
Mary Jane H. Linn same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic obstructive pulmonary disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24 hours

7 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Rheumatoid arthritis

MEDICAL CERTIFICATION

19a. DATE OF OPERATION
—

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
—

20a. AUTOPSY?
YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-13, 1986, to 9-16, 1986, that (I) (we) last saw the deceased alive on 9-7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.

22b. SIGNATURE
Stanley J. Talpers M.D. DEGREE
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED
Sept. 16, 1986

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stanley J. Talpers, M.D.

22e. ADDRESS
2141 K Street, N.W. Washington, D.C. 20037

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
Sept. 20, 1986

23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery

23d. LOCATION
CITY OR TOWN COUNTY STATE
Detroit Michigan

24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey Funeral Homes, P.A. ADDRESS
7557 Wisconsin Ave. Bethesda, Maryland 20814

25a. DATE REC'D. BY REGISTRAR
SEP 19 1986

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

Autonomous body

that is known

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hour after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 3 5 5			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LOUISE LAST HOFFMAN				2a. DATE OF DEATH MONTH DAY YEAR 7-31-86			
3. SEX FEMALE				2b. HOUR 7:30 p.m.			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 8, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER		12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPR. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 15004-HASELMERE CT. 20910			
14. FATHER'S NAME FIRST HENRY MIDDLE -- LAST HOFFMAN				15. MOTHER'S MAIDEN NAME FIRST JOHANNA MIDDLE M. LAST LUDTKE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-18-3541		17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD-NLH-ROCKVILLE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxiation</u> (c) <u>Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
22a. I certify that (1) this hospital attended and deceased from <u>May 31</u> 19 <u>81</u> , to <u>July 31</u> 19 <u>81</u> , that (1) I saw the deceased alive on <u>July 31</u> 19 <u>81</u> and that in my opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Booley, MD</u>				DEGREE		DATE SIGNED <u>Aug 1, 1986</u>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas Booley, MD</u>				22d. ADDRESS <u>17964 GEORGIA AVE OLIVER, MARYLAND 20832</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 4, 1986		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY STATE COUNTY SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HYSONG CO., INC-1300 N ST., NW WASH., DC				25. DATE REC'D BY REGISTRAR AUG 08 1986			
				26. REGISTRAR'S SIGNATURE <u>Julia Benson-Landrum</u>			

BP

100



00-19434

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVELYN M HOLCOMB			2a. DATE OF DEATH MONTH DAY YEAR 9 18 86			2b. HOUR 2100 M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR FEB. 20, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 310 Seth Place 20850		
14. FATHER'S NAME FIRST MIDDLE LAST Carl D. Dickenson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Mullins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 220-20-1281		17. INFORMATION 310 Seth Pl. Rockville, Md. 20850 Nebraska Holcomb (husband)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic colon carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: psoriasis, hypertension, diabetes											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D. Dickenson				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/18/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis Dickenson				22e. ADDRESS 15225 Shady Grove Rd, Rockville MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/23/86		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR Edison Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 100-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26351	
1. DECEASED NAME (TYPE OR PRINT) JULES HOLLANDER										2a. DATE OF DEATH Aug 24 1986	
3. SEX M 4. RACE WHITE 5. DATE OF BIRTH Sept 9 03 82 6. AGE (IN YEARS) 82 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.										2b. DATE OF DEATH ESTIMATED Aug 24 1986	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C. 9b. CITIZEN OF WHAT COUNTRY? U. S. A. 9c. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.										2c. DATE PRONOUNCED DEAD Aug 24 1986	
10. CITY OR TOWN OF DEATH Bethesda 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Advent. Hosp 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dry Cleaning 12b. KIND OF BUSINESS OR INDUSTRY Owner										12c. DATE PRONOUNCED DEAD Aug 24 1986	
13a. STATE Florida 13b. COUNTY Boca Raton 13c. CITY OR TOWN Boca Raton 13d. INSIDE CITY LIMITS? YES XX NO B 13e. STREET ADDRESS 3025 Hythe B										13f. STREET ADDRESS 9999	
14. FATHER'S NAME Morris Hollander 15. MOTHER'S MAIDEN NAME Belle (Unascertainable)										16. SOCIAL SECURITY NO. 579-40-3487-A	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 17. INFORMANT Susan L. Kopper ADDRESS 10504 Saddlebrook Court, Laurel, Maryland 20707										17. INFORMANT ADDRESS 10504 Saddlebrook Court, Laurel, Maryland 20707	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dist DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last, (b) Chronic Myocardial Dist DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. None											
19a. DATE OF OPERATION None 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE										21g. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE John S. Rogers M.D. 1986 MEDICAL EXAMINER DATE SIGNED Aug 24 1986										23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 8/26/1986 23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon 23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, P. G., Md.	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. 25a. DATE REC'D. BY REGISTRAR AUG 28 1986 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall										25a. DATE REC'D. BY REGISTRAR AUG 28 1986 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Annie T. Hopkins			2a. DATE OF DEATH MONTH DAY YEAR Sept. 11, 1986		2b. HOUR 5:22 p	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 2, 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 86		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TN		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5406 Trent St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		
12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 5406 Trent St. / 20815		
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Chevy Chase		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Tolmie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Howell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-40-0063		17. INFORMANT ADDRESS Cecelia Porter Same as item # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> 19 <u>86</u> to <u>Sept 12</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 8</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>George A. Boinis M.D.</u>		DEGREE		22c. DATE SIGNED <u>Sept. 12/1986</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George A. Boinis, M.D.		22e. ADDRESS 5410 CT Ave. NW Wash., DC 20015				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/15/86		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, VA		24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016				
25a. DATE REC'D. BY REGISTRAR SEP 16 1986		25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released By Dr. Tauber.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

Table 1. Total population, by race and sex, 1960

Race	Male	Female	Total
White	100,000,000	100,000,000	200,000,000
Black	10,000,000	10,000,000	20,000,000
Hispanic	5,000,000	5,000,000	10,000,000
Other	5,000,000	5,000,000	10,000,000

Table 2. Total population, by race and sex, 1970

Race	Male	Female	Total
White	110,000,000	110,000,000	220,000,000
Black	12,000,000	12,000,000	24,000,000
Hispanic	6,000,000	6,000,000	12,000,000
Other	6,000,000	6,000,000	12,000,000

Table 3. Total population, by race and sex, 1980

Race	Male	Female	Total
White	120,000,000	120,000,000	240,000,000
Black	13,000,000	13,000,000	26,000,000
Hispanic	7,000,000	7,000,000	14,000,000
Other	7,000,000	7,000,000	14,000,000

00-18366

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 5 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret E. Hopson			2a. DATE OF DEATH MONTH DAY YEAR 9/15/1986			2b. HOUR 4:10P M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 15 1914		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS . 72		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 Finale St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 201 Finale St. 20907	
14. FATHER'S NAME Able Jones				15. MOTHER'S MAIDEN NAME Olive Jackson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 159-22-8107		17. INFORMANT ADDRESS Willette Ingraham same as 13e					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
MinutesConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Widely metastatic carcinoma

6 months

DUE TO, OR AS A CONSEQUENCE OF

(c) Carcinoma of the left breast

7 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) XXXXXX attended the deceased from August 14, 1986, to September 15, 1986, that (I) XX lost saw the deceased alive on September 15, 1986, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard P. Delaney</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.		22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial Removal		23b. DATE 19 Sept 86		23c. NAME OF CEMETERY OR CREMATORY Allegheny Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pittsburgh, Pa.	
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home				25a. DATE REC'D. BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

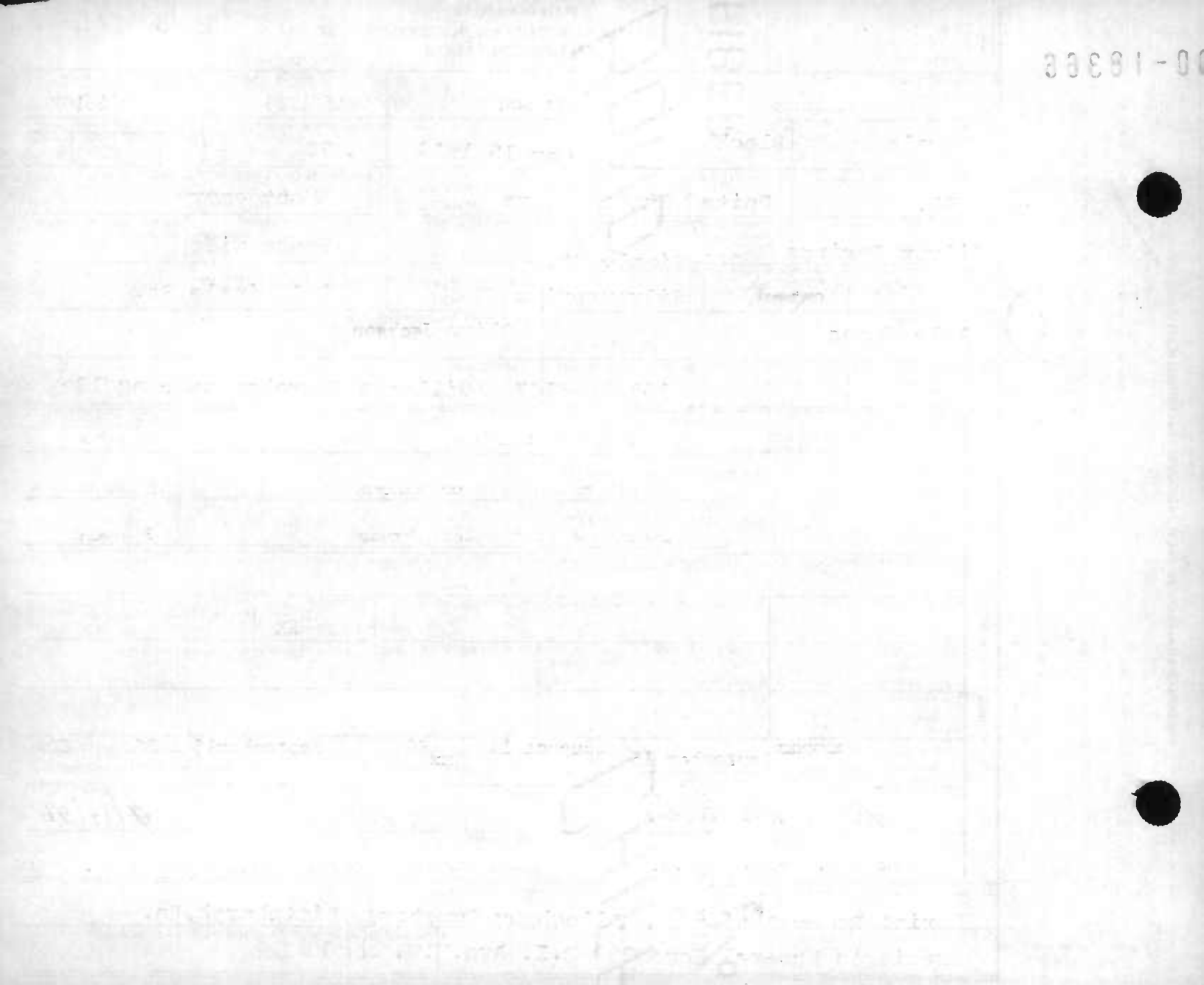
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

DHMH - 16 50M 4/83
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

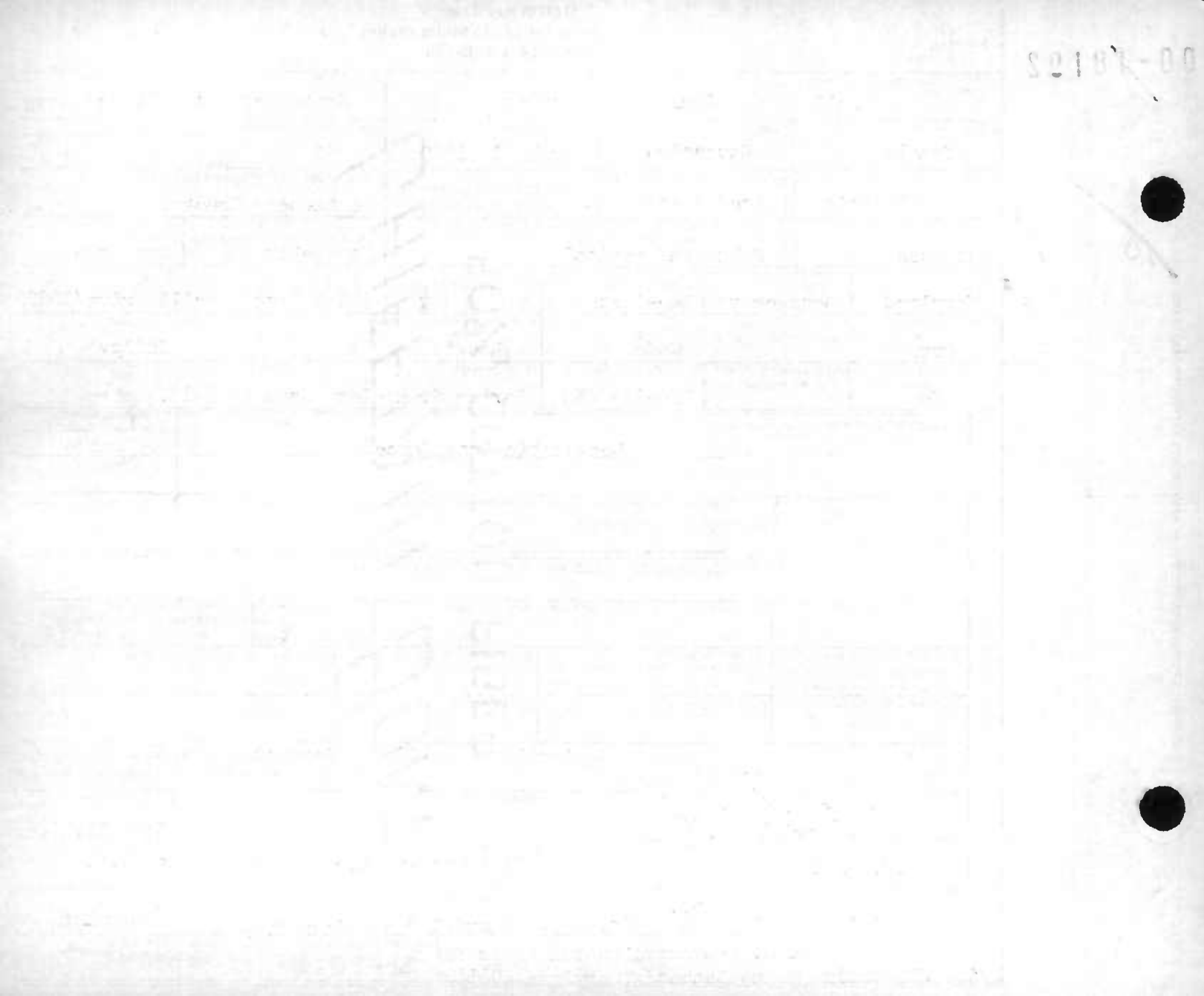
8 8 2 6 3 6 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nell Jane Hosler			2a. DATE OF DEATH MONTH DAY YEAR September 12, 1986		2b. HOUR 12:45PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 13, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Orren Wade		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lessie Bailey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 324-14-0463		17. INFORMANT ADDRESS Harlan S. Hosler Same as # 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>86</u> , to <u>Sept 12</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>F.P. Smith</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept 12, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.P. Smith M.D.		22e. ADDRESS 5401 Western Ave N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE SEP 16 1986 <i>John Davidson</i>			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey 7557 Wisconsin Avenue Bethesda, Maryland 20814					

BP



00-20031

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH HELEN HUEY				2a. DATE OF DEATH MONTH DAY YEAR 09 26 86			
3. SEX FEMALE				2b. HOUR 1030p M			
4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 01 20 21		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL, BETHESDA		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPR.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH NMN SERES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBARBA NMN KANTOR		13e. STREET ADDRESS / ZIP CODE 11511 SOWARD DRIVE 20902			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 01/44-07/46 043-12-7269		17. INFORMANT ADDRESS JOHN NMN HUEY / SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CANDIDA SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JULY 9 , 19 86 , to SEPT 26 , 19 86 , that (I) (we) lost saw the deceased alive on SEPT 26 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward P. Fox				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 27 Sept. 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD P. FOX, LT, MC				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-28-1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.				ADDRESS 20910 SILVER SPRING, Md.		25a. DATE REC'D. BY REGISTRAR 06/06/1986	
				25b. REGISTRAR'S SIGNATURE Jane Davidson-Henderson			

BP



00-18100

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRACE M. HUTCHINSON			2a. DATE OF DEATH MONTH DAY YEAR 09 14 86			2b. HOUR 11:35A.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 15 10		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Self-emp.	
13a. STATE MD.		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Emily				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 156-26-5616		17. INFORMANT NAME ADDRESS Wilbur Pinder (son) same as #13				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) End Stage Renal Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: End Stage Renal Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/8 , 19 86 , to 9/14 , 19 86 , that (I) (we) lost saw the deceased give on 9/14 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Raymond Bass		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-14-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS		22e. ADDRESS 3941 Fenwa Dr Wheaton Md 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9-15-86		23c. NAME OF CEMETERY OR CREMATORY Bragg Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Paterson, Passaic Co, NJ			
24. FUNERAL DIRECTOR NAME George R. Snowden		246 N. Washington ADDRESS Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR SEP 16 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

00181-00

1. DECEASED NAME
(TYPE OR PRINT)

REG. NO.

SEP 10 1965

DHMH - 17
(VR A15 ME (5))

VOID

CERTIFICATE # 86-26364

00-17466

FOR
1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

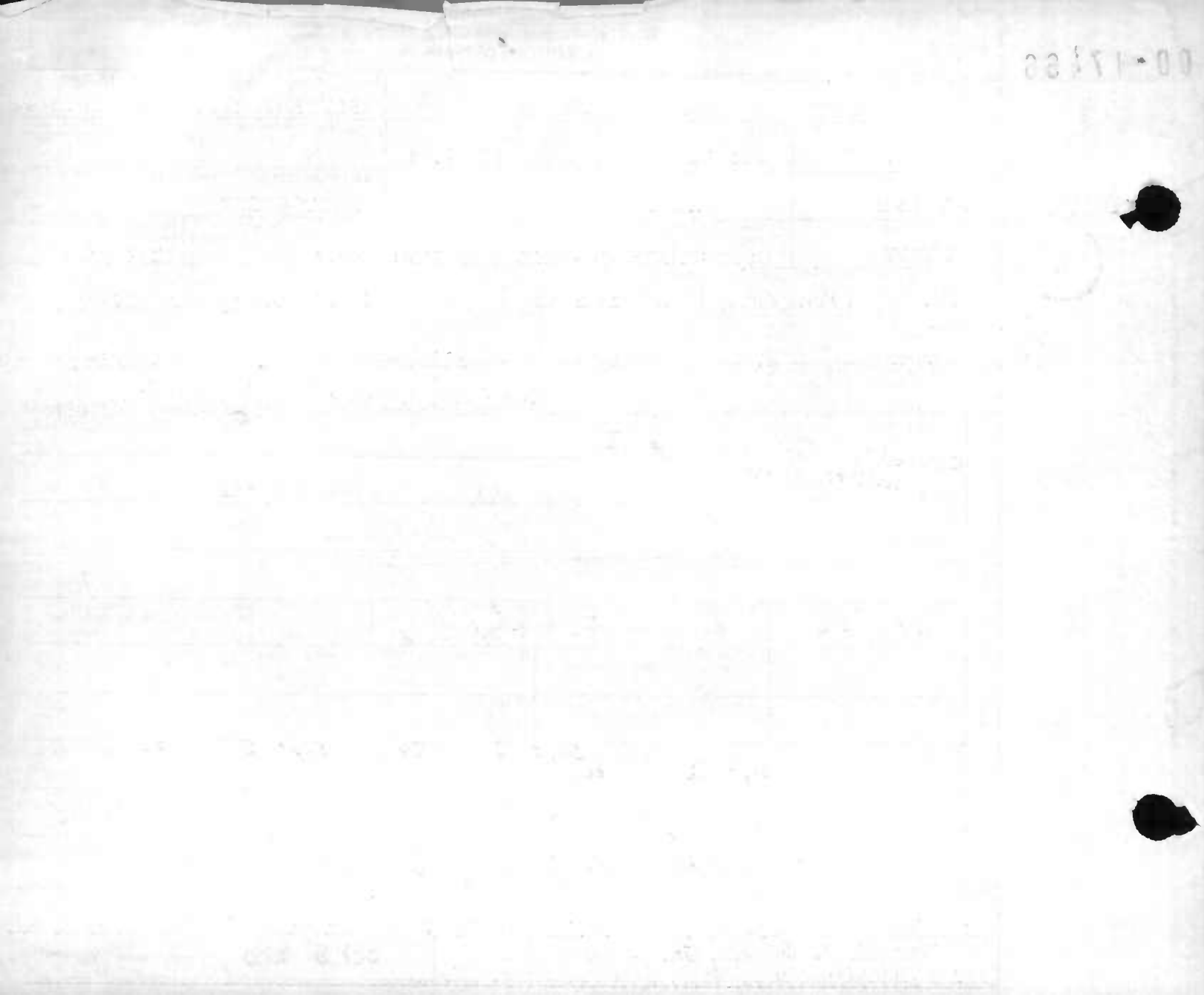
REG. NO.

26000

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
DORIS			A.	JAMES		SEPTEMBER 2, 1986						10:50PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
F.		Caucasian		May 21 1904		82 YRS			MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Arkansas		U.S.A.				MONTGOMERY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
OLNEY		MONTGOMERY GENERAL HOSPITAL		Housewife		Housewife							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE							
Md.		Montgomery		Silver Spring <input type="checkbox"/> NO <input type="checkbox"/>		15016 Eardley Ct. 20906							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST			FIRST MIDDLE LAST										
George E. Carroll			Elizabeth A. Williams										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
no			N/A			Charlotte A. Davis			9103 Louis Ave. Silver Spring, Md 20910				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>MI</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>past cerebral disease, 4 mo S/P MIE</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>port of ischemia</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
9/2/86			distal aorta, bilateral iliac thromb.			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> , 19 <u>86</u> , to <u>Sept 2</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			22c. DATE SIGNED							
Roya Moazzam, M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			9/2/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
ROYA MOAZZAM I, M.D.			Montgomery General Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
Burial			Sept. 5, 1986			Et. Lincoln Cemetery			Brentwood Prince Georges Md.				
24. FUNERAL DIRECTOR			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Francis J. Collins, Jr.			SEP 9 1986										
500 University Blvd., West, Silver Spring, Md. 20901													

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



00-18682

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Johnson			2a. DATE OF DEATH MONTH DAY YEAR 9-10-1986			2b. HOUR 3:30 AM				
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 18 1944		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.				
10. CITY OR TOWN OF DEATH Sil. Spr, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY Veteran Adm.		
13a. STATE D.C.			13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3616 B Street, S.E. #302	
14. FATHER'S NAME FIRST MIDDLE LAST Michael E. Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Montgomery							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-58-2458		17. INFORMANT ADDRESS Barbara Ann Johnson (Sister) 1515 Benning Road, N.E. #22 Wash, DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia with DUE TO, OR AS A CONSEQUENCE OF (b) Adult Respiratory Distress Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Hypertension										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-22 , 19 86 , to 9-10 , 19 86 , that (I/we) last saw the deceased alive on 9-9 , 19 86 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.										
22b. SIGNATURE Hazel M. Tape, MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-11-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAZEL M. TAPE, MD			22e. ADDRESS 1011 North Capitol ST, N.E. WASH, DC.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 13 '86		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland			
24. FUNERAL DIRECTOR NAME R. N. Horton Co. 600 Kennedy St., N.W.			Wash. D.C.			DATE RECEIVED BY REGISTRAR SEP 19 1986				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-18883



COTTON FIBER

WATER MARK

0-18717

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 3 0 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Harold Donald Jones</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 17 86</i>		2b. HOUR <i>10:00 AM</i>
3 SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 20, 1926</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Trouble Shooter</i>		12b. IND. OF BUSINESS OR INDUSTRY <i>Power & Light Co</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Bolden Jones</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bettie Hammond</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>WW II 212-24-4202</i>		17. INFORMANT ADDRESS <i>Roberta V. Jones (wife) same as 13e</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Acute hemorrhagic pancreatitis, renal failure</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18; PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>8/28</i> 19 <i>86</i> to <i>9/17</i> 19 <i>86</i> that (1) (we) last saw the deceased alive on <i>9/17</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If how (did) (did not) view the body after death.					
22b. SIGNATURE <i>Samuel D. Goldberg</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>9/17/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Samuel D. Goldberg</i>		22e. ADDRESS <i>11125 Rockville Pike Rockville, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/23/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bellevue Cedar Hill Memorial Gardens Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Daytons Beach, Florida</i>		23e. DATE REC'D. BY REGISTRAR <i>SEP 22 1986</i>			
24. FUNERAL DIRECTOR NAME <i>Tyson Wheeler Funeral Home, Inc.</i> <i>1331 Rockville Pike, Rockville, Md. 20852</i>		25a. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (item 4 may be retained by the hospital or attending physician).

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. Then please remove to Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

00-17597

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 8 2 6 3 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
KEITH GEORGE JONES						SEPTEMBER 5 1986			4:50 A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		BLACK		MAY 15 1949		37 YRS.			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
WEST INDIES		UNITED STATES				MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NAVAL HOSPITAL				U.S.A.F.			DEFENSE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
NEW JERSEY		BURLINGTON		BROWNS MILLS				1115 SCAMMELL DRIVE 08015				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
KENNETH GEORGE JONES				EDNA MAE GREENE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
YES		1970-1986		111-46-9965		PATSY JONES, 1115 SCAMMELL DRIVE, BROWNS MILLS, NJ 08015						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 3, 1986, to SEPTEMBER 5, 1986, that (I) (we) last saw the deceased alive on SEPTEMBER 5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert P. Dolan DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/5/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. P. DOLAN, LT, MC, USNR						22e. ADDRESS NAVAL HOSPITAL BETHESDA, MARYLAND 20814-5011						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 09/15/86		23c. NAME OF CEMETERY OR CREMATORY N. J. Vet. Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arnesytown New Jersey					
24. FUNERAL DIRECTOR Lee Funeral Home, Inc. NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE						
16638 Old Alexander Ferry Rd Clinton, Md. 20735						SEP 10 1986						

00-15207



100-15207

00-19119

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 7 0

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ann Estella Kandle			2a. DATE OF DEATH MONTH DAY YEAR September 22, 1986			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 2, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 yrs. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME Charles A. Eckstein				15. MOTHER'S MAIDEN NAME Margaret (unavailable) Heath			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-09-5405		17. INFORMANT Helen McManemin, Sister, 5207 Ventnor Rd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 MMED

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

BREAST CANCER

10 YRS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>82</u> , to <u>PRESENT</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>AUG 23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE Dr. Jon M. Wiseman				22c. DATE SIGNED 22 SEPT 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jon M. Wiseman				22e. ADDRESS 5410 Conn. Ave., NW., #103 Wash., DC			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION (CITY OR TOWN) COUNTY STATE Alexandria, Virginia	
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24. FUNERAL DIRECTOR DeVol Funeral Home, Inc. 2222 Wisc. Ave., NW., Wash., DC		25. DATE REC'D BY REGISTRAR SEP 26 1986		25. REGISTRAR'S SIGNATURE John F. Dally	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01-101-00

00-18494

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MOSES PHILLIP KATZ			2a. DATE OF DEATH MONTH DAY YEAR September 18, 1986		2b. HOUR 6 a.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8200 Wisconsin Ave., #615				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney (Ret.)		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 8200 Wisc. Ave., #615 (20814)		
14. FATHER'S NAME FIRST MIDDLE LAST Louis Katz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Baer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Maryland 20814 Dorothy Katz; 8200 Wisc. Ave., #615; Bethesda,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Cerebral Vascular Disease								
19a. DATE OF OPERATION 9/16/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystectomy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from September 19, 1979 to 9/18/86 , that (I) (we) last saw the deceased alive on 9/16/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Gary Fisher MD				DEGREE MD		22c. DATE SIGNED 9/18/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY FISHER, MD				22e. ADDRESS 5530 Wisconsin Ave				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/19/86		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va.		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. DATE REC'D. BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE W. Davidson		
1170 Rockville Pike; Rockville, Md. 20852								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

42481-00

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 1 2

FOR
1- STATE
REGISTRAR

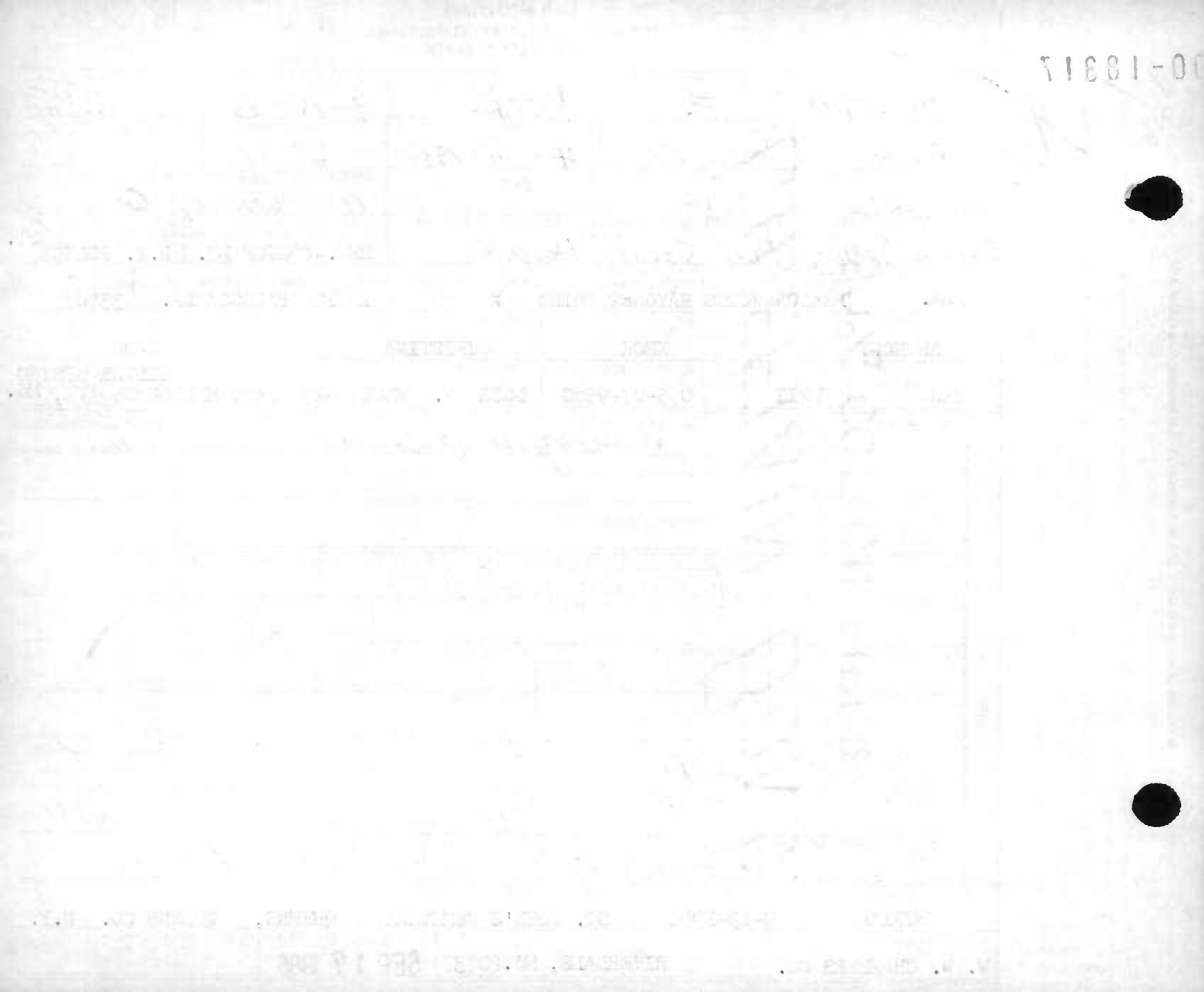
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph F. Keck			2a. DATE OF DEATH MONTH DAY YEAR 9-15-86			2b. HOUR 3:25 A.M.	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4-7-1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET.-POLICE LT.		12b. KIND OF BUSINESS OR INDUSTRY N.Y. POLICE DEPT.	
13a. STATE FLA.		13b. COUNTY BEACON WOODS		13c. CITY OR TOWN BAYONET POINT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 12412 PADDOCK LA. 33567		14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY KECK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHRISTINA WARD		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	
16b. SOCIAL SECURITY NO. 055-07-9580		17. INFORMANT LOIS T. KECK		ADDRESS 417 EAST MELBOURNE AVE, Md.		SILVER SPRING	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchovascular</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Pulmonary Embolism</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>8 Aug 1986</u> to <u>15 Sep 1986</u> , that (I) (we) last saw the deceased alive on <u>14 Sep 1986</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <u>Michael Leibman MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 15 Sep 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibman MD		22e. ADDRESS 1120 K H Ave S Apt 20307					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-19-1986		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE QUEENS, QUEENS CO. N.Y.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR SEP 17 1986	
				25b. REGISTRAR'S SIGNATURE <u>Ann Randa</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 allows any injury, or other traumatic event, the medical examiner must be notified at once.



00-20089

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward F. Kelly			2a. DATE OF DEATH MONTH 09 DAY 29 YEAR 86			2b. HOUR 5:55 ^P				
3. SEX male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 12 DAY 02 YEAR 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS 00 DAYS 00 HOURS 00 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY AIR Transport Assoc		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD			13b. COUNTY Queen Anne		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Queen Anne's Road 21619	
14. FATHER'S NAME FIRST Michael MIDDLE Kelly LAST Kelly			15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Daugherty LAST Daugherty			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO. 206-01-8385			17. INFORMANT son ADDRESS Rockville, Maryland			17b. ADDRESS Dennis J. Kelly 401 W. Montgomery Ave. 20850				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (b) Continuing bleeding from rectal sigmoid Radiation proctitis DUE TO, OR AS A CONSEQUENCE OF (c) Radiation therapy for transitional cell carcinoma of the bladder								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 6 months 18 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT LISTED IN THE TERM OF DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET Shields Drive CITY OR TOWN Bethesda COUNTY MD STATE MD					
22a. I certify that (I) (the hospital) attended the deceased from 14 May 1986 to 29 September 1986 , that (I) (we) last saw the deceased alive on 29 September 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.										
22b. SIGNATURE Michel M. Healy			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/30/86		
22d. PHYSICIAN'S NAME (PRINT) Michel M. HEALY M.D.			22e. ADDRESS 5752 Shields Drive, Bethesda MD, 20817							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 2, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		23d. LOCATION CITY OR TOWN Queenstown COUNTY Queen Anne's STATE Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Boulevard West, Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR OCT 06 1986 25b. REGISTRAR'S SIGNATURE John W. Gordon							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, a medical examiner must be notified at once.

1-17507

7-37

11111

Handwritten scribbles

70

unclassified

USA

Penetration

Foreign

Current and local

Foreign: Green Area: Chester

111-102 Washington Ave.
Baltimore, Md. 20122



011-61-2176 Bureau of

Thomas

206

Handwritten scribbles

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62

June 11

52

16

Jan 66

June 11

xx

Washington State and the Northwest

June 11, 1966 St. Peter's University

Local

500 University Blvd., N. Silver Spring, Md.
Thomas J. Collins, Jr.
June 11, 1966

20
00-16525

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26375

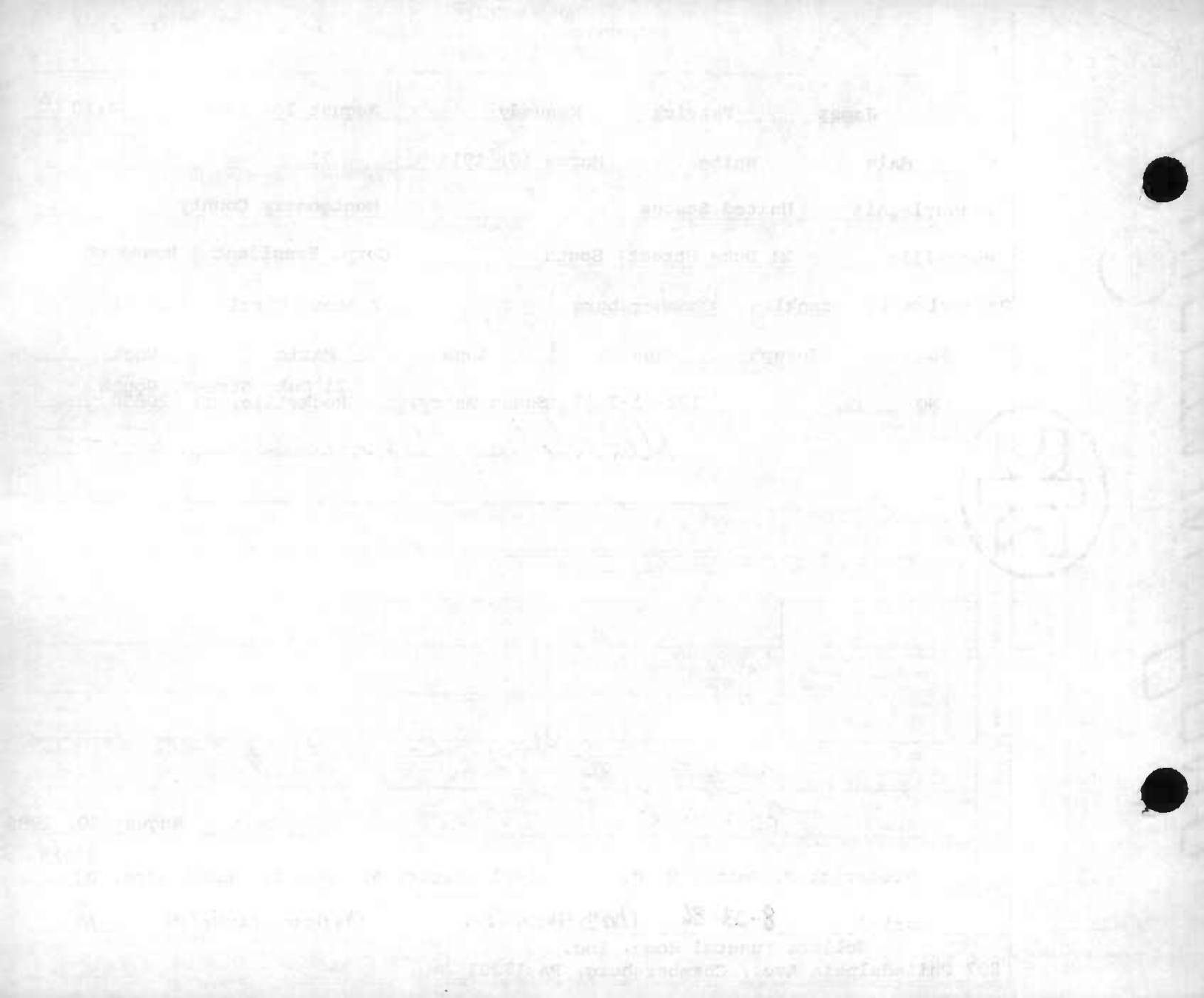
FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Patrick Kennedy			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1986			2b. HOUR 4:10 A				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 10, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21 Duke Street, South				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Corp. President		12b. KIND OF BUSINESS OR INDUSTRY Research		
13a. STATE Pennsylvania			13b. COUNTY Franklin		13c. CITY OR TOWN Chambersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7 Acorn Circle / 17201	
14. FATHER'S NAME FIRST MIDDLE LAST John Joseph Kennedy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Marie Hook							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 182-01-2617		17. INFORMANT Susan Mabry,		21. Duke Street, South Rockville, MD 20850				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Melanoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 1985 to Aug 1986 , that (I) (we) last saw the deceased alive on Aug 19 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED August 20, 1986				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick P. Smith, M. D.			22e. ADDRESS 5401 Western Avenue, NW, Washington, DC 20015							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-23-86		23c. NAME OF CEMETERY OR CREMATORY CORPUS CHRISTI CEM		23d. LOCATION CITY OR TOWN COUNTY STATE CHAMBERG FRANKLIN PA				
24. FUNERAL DIRECTOR NAME ADDRESS Sellers Funeral Home, Inc. 297 Philadelphia Ave., Chambersburg, PA 17201						25a. DATE REC'D. BY REGISTRAR AUG 26 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

(IMPORTANT) If item 21 is marked or item 18 shows any injury, or other traumatic event, then a copy of this certificate must be filed in the file.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADA Muriel KERR			2a. DATE OF DEATH MONTH DAY YEAR September 4, 1986		2b. HOUR 9:20A.M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 10, 1892		
6. AGE (IN YEARS-LAST BIRTHDAY) 93		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		13. STREET ADDRESS / ZIP CODE 22 Ridge Road 20770		
14. FATHER'S NAME FIRST MIDDLE LAST James H. Esq		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary F. Cash		16. SOCIAL SECURITY NO. 217-52-6500		
17. INFORMANT Walter H. Kerr (Son)		18. ADDRESS 8802 Wells Parkway Hyattsville, Md. 20782		19. DATE OF OPERATION		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> , 19 <u>86</u> , to <u>Sept 4</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23a. SIGNATURE <i>John J. Merendino</i>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		23c. DATE SIGNED 9-4-86	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Merendino, M.D.				23d. ADDRESS 4701 Randolph Rd., #216, Rockville, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09/06/86		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR FRANK'S GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 9 1986 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

10451-1



0-17705

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 7 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BADRELMLOUK KHAVAND			2a. DATE OF DEATH MONTH DAY YEAR August 19, 1986			2b. HOUR 9:00 A			
3 SEX FEMALE		4 RACE IRANIAN		5 DATE OF BIRTH MONTH DAY YEAR MAY 19, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7b. HOUR 9:00 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRAN		7b. CITIZEN OF WHAT COUNTRY? IRAN		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH SHADY GROVE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. CITY OR TOWN FREDERICK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1# 19 North Market Street 21701			
14. FATHER'S NAME FIRST MIDDLE LAST MAHMMOUD KHAVAND				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ATIEH TAHMASEBY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219 08 5655		17 INFORMANT ADDRESS ABDOL BAHRAMI 19 N. Market Frederick, MD 21701					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 HOURS 10 HOURS 15 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, HYPERTENSION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 85 , to 8-19 , 19 86 , that (I) (we) last saw the deceased alive on 8-18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hoang Can M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8.20.86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOANG CAN, MD				22e. ADDRESS 1100 Kersey Road Silver Spring, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE *8/20/86		23c. NAME OF CEMETERY OR CREMATORY National Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Fairfax VA			
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE				ADDRESS 2617 PA Ave SE Wash., D.C.				25a. DATE REC'D. BY REGISTRAR SEP 03 1986	
				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

MEDICAL CERTIFICATION

978501

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-15502

RECEIVED

MINUTE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

18741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					MONTH DAY YEAR						
2. SEX					2b. HOUR						
3. RACE					9 19 86 9 A M						
4. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)						
5. MONTH DAY YEAR					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.						
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7. BALTIMORE CITY OR COUNTY OF DEATH						
7. CITIZEN OF WHAT COUNTRY?					MD.						
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH						
10. CITY OR TOWN OF DEATH					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE					13b. COUNTY						
13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.						
17. INFORMANT					ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ovarian Cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mo.						
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 2/18/86 to 9/19/86, that (2) (we) last saw the deceased alive on 7/1/86, and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Peter Sherer						DEGREE MD		22c. DATE SIGNED 9/19/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer						22e. ADDRESS 3947 Ferrara Dr. Wheaton Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT. 22, 1986			23c. NAME OF CEMETERY OR CREMATORY KLINE CEMETERY			23d. LOCATION UPPER TRACT PENDLETON WEST VA.		
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		

SEP 22 1986

LIBEL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 7 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lois M. Kinsinger			2a. DATE OF DEATH MONTH DAY YEAR 9-26-86		2b. HOUR MIN. 7:10 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 2, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James Maupin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Firey		13e. STREET ADDRESS / ZIP CODE 733 Sligo Avenue # 605 20910	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-64-1112		17. INFORMANT nephew ADDRESS 2519 Ennalls Avenue Wheaton, Maryland 20902	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Congestive Heart Failure, Arteriosclerotic Heart Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/3 , 19 86 , to 9/26 , 19 86 , that (I) (we) last saw the deceased alive on 9/25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Antonio G. Uy		DEGREE M.D.		22c. DATE SIGNED 9/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO G. Uy		22e. ADDRESS 831 University Blvd E. & N. Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 29, 1986	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Md.
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR OCT 03 1986		
500 University Blvd., W. Silver Spring, Md.			25b. REGISTRAR'S SIGNATURE		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as any injury, or other traumatic event, the medical examiner must be notified at once.

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00-20091

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Ruth E. KLine					2a. DATE OF DEATH MONTH DAY YEAR 9-29-86		2b. HOUR 1303 PM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 3 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Singer Co.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9106 Sudbury Rd. 20901			
14. FATHER'S NAME FIRST MIDDLE LAST Rudolph O. Eyler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Currans							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 218-30-4590		17. INFORMANT husband ADDRESS L. William Kline same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Emphysema											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/18 , 19 86 , to 9/25 , 19 86 , that (I) (we) last saw the deceased alive on 9/25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joel Schuman				DEGREE Coroner ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/29/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schuman				22e. ADDRESS 94p 012 Georgetown Rd Bethesda							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 3, 1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Boulevard West, Silver Spring, Md.				25a. DATE REG'D. BY REGISTRAR 10/16/86		25b. REGISTRAR'S SIGNATURE [Signature]					

BP _____

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00-19867

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE LAST FIRST MIDDLE) Roland Royce Kneece			2a. DATE OF DEATH MONTH DAY YEAR 9/27/85		2b. HOUR 6 A.M.
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10/12/14		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1126 W. Nolcrest Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cartographer		12b. KIND OF BUSINESS OR INDUSTRY D. of Agricult.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1126 W. Nolcrest Drive 20903	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Furman Kneece			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Callie Sawyer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 260-26-3642		17. INFORMANT wife ADDRESS Katherine P. Kneece same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/29/85 to 9/27/85, that (I) (we) last saw the deceased alive on 9/13/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE EDGAR H. LGVIN		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LGVIN		22e. ADDRESS 9801 Greenleaf Ave. Silver Spring Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 1, 1986	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Memorial Gdns.	23d. LOCATION CITY OR TOWN COUNTY STATE Spartanburg Spartanburg S.C.
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR OCT 03 1986	
500 University Boulevard West, Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 0 2 5 3 8 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HILDA KOBER			2a. DATE OF DEATH MONTH DAY YEAR 9 19 86		2b. HOUR 230 P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH February 1, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH KENSINGTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENSINGTON GARDENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER	12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CHAIM BERLIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHANA (Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-62-4828		17. INFORMANT 909 HYDE ROAD DAVID KOBER, SILVER SPRING, MARYLAND	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction (CHARTERED ADROCA) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Hypertension, an old patient's condition			
19a. DATE OF OPERATION 12/22	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from 12/22 , 19 86 , to 12/23 , 19 86 , that (I) have last saw the deceased alive on 9/11 , 19 86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.			
22b. SIGNATURE Barrett Lewis Burka		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/15/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BARRETT LEWIS BURKA, M. D.		22e. ADDRESS 4607 CONNECTICUT AVENUE, N. W. WASHINGTON, D. C.	

23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 9/21/1986	23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY	23d. LOCATION CITY OR TOWN STATE DELPHI, PRINCE GEORGES, MARYLAND
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR SEP 24 1986	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to provide a post-mortem.

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00-19752

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

~~TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 7 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WESTERN STREET,
ALBANY, N.Y. 12210 PRIOR TO BURIAL, CREMATION, OR REMOVAL.~~

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(VR A15 ME (5))

STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		6 2 6 3 8 3	
FOR STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH	
PATRICK K. KREITZER				2b. DATE OF DEATH ESTIMATED	
				9 21 1986	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		Caucasian		March 10, 1966	
6. AGE (IN YEARS)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?	
20 YRS.		Maryland		USA	
9. MARRIED		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
NEVER MARRIED		Kensington		Rt. 495 e. of Connecticut Ave.	
WIDOWED					
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY		14. BALTIMORE CITY OR COUNTY OF DEATH	
Attendant		Service Station		Montgomery County	
15. INSIDE CITY LIMITS?		16. STREET ADDRESS		17. CITY OR TOWN	
YES		4405 Olando Lane		20715	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. SOCIAL SECURITY NO.	
William G. Kreitzer		Dolores A. Lippard		215-98-9438	
21. WAS DECEASED EVER IN U.S. ARMED FORCES?		22. INFORMANT		23. ADDRESS	
NO		William G. Kreitzer		4405 Olando Lane	
		Bowie, MD		20715	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1	
8121 IMMEDIATE CAUSE (a) Multiple injuries					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED?		29. AUTOPSY?	
				YES NO	
30. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		31. TIME OF INJURY		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
1:45 PM 9-21-1986		Passenger of auto/parked truck collision.			
33. INJURY OCCURRED WHILE AT WORK		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		35. LOCATION	
NOT WHILE AT WORK		road		Rt. 495 e. of Connecticut Ave., Montgomery, MD	
36. I certify that I took charge of the remains described above, held an autopsy		37. Inspection		38. Inquiry	
Natural cause		Accident		Suicide	
Undetermined manner					
39. ACTUAL SIGNATURE		40. TITLE (SPECIFY)		41. DATE SIGNED	
Dennis F. Smyth, M.D.		Assistant		9-21-86	
42. EXAMINER'S NAME (TYPE OR PRINT)		43. ADDRESS		44. CITY OR TOWN	
Dennis F. Smyth, M.D.		111 Penn St., Balto., MD		21201	
45. BURIAL, CREMATION, REMOVAL (SPECIFY)		46. DATE		47. NAME OF CEMETERY OR CREMATORY	
Burial		SEPT 24, 1986		Ft. Lincoln Cemetery	
48. FUNERAL DIRECTOR NAME		49. ADDRESS		50. CITY OR TOWN	
Beall Funeral Home		16000 Annapolis Road		Brentwood, Pr. George's, MD	
51. DATE REC'D. BY REGISTRAR		52. REGISTRAR'S SIGNATURE		53. DATE REC'D. BY REGISTRAR	
OCT 02 1986					

00-10725

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JAN 11 1952

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JAN 11 1952



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/STP

00-18775

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sofia Kriljenko</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>09/21/86</i>		2b. HOUR <i>1415</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 29 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>85</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Yugoslavia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Yugoslavia</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Vujich</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Angelina Bucheich</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Ezio Vermiglio Same as # 13.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Eos hypersensitivity</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Eos hypersensitivity</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>2/6</i> 19 <i>81</i> to <i>9/21</i> 19 <i>86</i> . That (I) <i>(we)</i> last saw the deceased alive on <i>9/21</i> 19 <i>86</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> did <i>(not)</i> view the body after death.							
22b. SIGNATURE <i>Lewis N. Cahill MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>9/21/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LEWIS N. CAHILL MD</i>				22e. ADDRESS <i>5411 W. Cedar Ln, Bethesda, Md 20814</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal/Burial</i>		23b. DATE <i>Sept. 24, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>British Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Calao Peru</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Robert A. Pumphrey Funeral Homes, PA 7557 Wisconsin Avenue Bethesda, Maryland 20814</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 22 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Kriljenko</i>	

MEDICAL CERTIFICATION

2

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-18772

1911-1912

1911-1912

1911-1912

RECEIVED NOTICE

1911-1912



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-19074
BH
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
LUDMILA KIRIN KUZNETSOVA						SEPTEMBER 11, 1986						8:35 ^P
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE		WHITE		APRIL 16, 1943			43 YRS			MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
USSR		U.S.A.					MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA		THE CLINICAL CENTER, NIH						WRITER				
13a. STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		20024		
DIST OF CO				WASHINGTON		YES <input type="checkbox"/> NO <input type="checkbox"/>		146 G Street, S.W.				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
FYODOR KIRIN				ANA IVANOUNA KIRINA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO				501-94-8218		ANNA KIRIN (DAUGHTER) SAME AS ABOVE						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) LYMPHOBLASTIC LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
			HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (he) (she) (it) attended the deceased from October 12, 19 82, to Sept 11, 19 86, that (we) (we) last saw the deceased alive on Sept 11, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
Kevin J. Cullen MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			9/12/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
Kevin J. Cullen						NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD. 20892						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
Burial			9-13-86		Rock Creek Cemetery			Washington DC				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Marshall's Funeral Home, Inc. 4217 9th Street, N.W., Washington, DC 20011						SEP 24 1986			John Deacon-Rodgers			

48001-0



00-190761

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26380

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Leonora M. Laesch</u>			2a. DATE OF DEATH MONTH <u>9</u> DAY <u>19</u> YEAR <u>1986</u>			2b. HOUR <u>11:15</u> MIN <u>A</u>			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>12</u> DAY <u>4</u> YEAR <u>1999</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>86</u> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Illinois</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>10012 Mayfield Drive</u>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>						

13a. STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>			13c. CITY OR TOWN <u>Bethesda</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>10012 Mayfield Drive 20817</u>		
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14. FATHER'S NAME FIRST <u>Henry</u> MIDDLE <u>Volstorff</u> LAST <u>Laesch</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Dorothea</u> MIDDLE <u>Margaretta</u> LAST <u>Schirrholtz</u>		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO <u>392-22-0967</u>		17. INFORMANT <u>Barbara Laesch</u>		ADDRESS <u>Same as #13</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ischemic + Congestive Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 3/13 19 86 to 9/19 19 86, that (I) (we) last saw the deceased alive on 9/19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Michael Emmer</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/19/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MICHAEL EMMER</u>				22e. ADDRESS <u>6316 Democracy Blvd Bethesda.</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Wednesday</u>		23b. DATE <u>24 Sept 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery Milwaukee</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Wisconsin</u>	
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24. FUNERAL HOME NAME <u>Robert E Wilhelm Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 25 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rudner</u>	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

WILLIAM
MAYNARD
C

23/1/62

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JULES LAFFERMAN			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 7, 1986			2b. HOUR P. 7:25 M				
1. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 18, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 367 SCOTT DR.				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LICENSED PUBLIC ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY ACCOUNTING		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 367 SCOTT DR. #20904	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL LAFFERMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA WINOKOUR						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-09-1604		17. INFORMANT MRS. NEYSA LAFFERMAN				ADDRESS 367 SCOTT DR. SILVER SPRING, MD 20904	
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Oct 19, 1982 to Time of Death 8/8 , that (I) (we) last saw the deceased alive on Aug 19, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Howard S. Goldstein						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/8/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard S. Goldstein						22e. ADDRESS 9701 Randolph Rd, Rockville, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT. 9, 1986		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.						25a. DATE REC'D. BY REGISTRAR SEP 11 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Hardell		
6010 REISTERSTOWN RD. BALTO., MD						21215				

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after data with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the need for a forensic autopsy may be required.

100-17638

00-15830

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-17406

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 0 3 0 0

1- FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SOL H LASH		2a. DATE OF DEATH MONTH DAY YEAR 9-4-86	
3. SEX Male		2b. HOUR 4:19 PM	
4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 7 13 05	
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kiev, Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSP	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		12b. KIND OF BUSINESS OR INDUSTRY PLUMBER CONSTRUCTION	
13b. COUNTY MONT		13c. CITY OR TOWN ROCKVILLE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6111 Montrose Rd. #1201 (20852)	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH LESCHINSKY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 376-09-7104	
17. INFORMANT ADDRESS Kensington, Md. 20895		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA TO DUE TO, OR AS A CONSEQUENCE OF (c) LUNG, PRIMARY SITE UNKNOWN CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours one month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110 PARKINSON'S DISEASE, CORONARY HEART DISEASE			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-3 86 to 9-4 86, that (I) (we) last saw the deceased alive on 9-3 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) and (we) view the body after death.			
22b. SIGNATURE OF PHYSICIAN		22c. DATE SIGNED 9-4-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL A. REISKIN, M.D.		22e. ADDRESS 50 W. EDMONSTON DRIVE ROCKVILLE, MD 20852	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sep. 5, 1986	
23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG		25a. DATE REC'D. BY REGISTRAR SEP 9 1986	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Name]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their plates remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REBILITATION

WINTER



15
00-18452STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 8 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE B. LAUG			2a. DATE OF DEATH MONTH DAY YEAR 09 16 86			2b. HOUR 11:14 P.M.	
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09 25 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4205 DRESDEN ST KENS, MD 20895		14. FATHER'S NAME FIRST MIDDLE LAST Charles Frederick Brede		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Voll	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577 502721		17. INFORMANT ADDRESS Edwin Laug (Husband) 4205 Dresden Street Kensington, Maryland 20895			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carotid arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hernia, intra-abdominal DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured aortic aneurysm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 1 hour							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Perforated sigmoid diverticulitis							
19a. DATE OF OPERATION 9-10-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated sigmoid diverticulitis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 10, 1986 to Sept 16, 1986 , that (I) (we) last saw the deceased alive on Sept 16, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Daniel Powers				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED September 17, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Powers M.D.				22e. ADDRESS 50 W. Edmonston Drive Rockville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE September 18, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes PA 7557 Wisconsin Avenue Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR SEP 19 1986			
				25b. REGISTRAR'S SIGNATURE John Davidson-Henderson			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rita			2a. DATE OF DEATH MONTH DAY YEAR September 30, 1986			2b. HOUR 10:15A_M		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR August 21, 1935		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? United States			6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS		
10. CITY OR TOWN OF DEATH Gaithersburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 Bethany Court			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Gaithersburg		
14. FATHER'S NAME FIRST MIDDLE LAST Vincenzo			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Concetta Peluso			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Confidential Secretary		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 133-26-2088			17. INFORMANT ADDRESS Mr. Francis A. Laurito, Husband, same as #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Metastatic Breast Cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

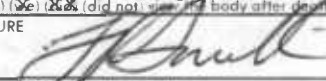
(b)


DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 yearsPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) did not attended the deceased from July , 19 82 , to September , 19 86 , that (I) do <input checked="" type="checkbox"/> saw the deceased alive on September 10 , 19 86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) do <input checked="" type="checkbox"/> did not see the body after death.							
22b. SIGNATURE 				DEGREE Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>		22c. DATE SIGNED Sept. 30, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick P. Smith, M.D.				22e. ADDRESS 5401 Wisconsin Avenue, N.W. Washington, D.C. 20015			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 3, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR OCT 03 1986			
300 West Montgomery Ave., Rockville, MD.				25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified at once.



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[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Elwood Lee								Sept. 23, 1986		9:53 pm	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Black		April 3, 1921		65		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				Montgomery				MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Olney		Montgomery General Hospital		Laborer		WSSC					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD		Montg.		Silver Spring		<input type="checkbox"/> NO <input type="checkbox"/>		1701 Pumphrey Lane/20904			
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Frank W. Lee		Beatrice Matthews									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
Yes		WWII		216-12-4629		Rhoda Smith (daughter)		19309 Elderberry Ter. Germantown, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>Aug</u> 19 <u>86</u> to <u>Sept 23</u> 19 <u>86</u> , that (1) (we) lost saw the deceased alive on <u>9/23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.		22b. SIGNATURE <u>Mark Rosen</u>		DEGREE		22c. DATE SIGNED <u>9/23/86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Mark Rosen		3941 Ferrara Drive, Silver Spring, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		9-30-86		Ash Memorial Cem.		Sandy Spring, Montg. MD					
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
George R. Snowden		246 N. Washington St. Rockville, MD 20850		SEP 29 1986		Julia Davidson-Randner					

MEDICAL CERTIFICATION

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Lecture" and "Notes" are faintly visible.]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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00-19547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 3 9 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MAGDA LeGETT				2a. DATE OF DEATH Sept 26 '86		2b. HOUR 5:50 AM	
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH Dec. 31 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse (retired)		12b. KIND OF BUSINESS OR INDUSTRY Private duty	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Foley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Courtney		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	
17. INFORMANT (daughter) Melvine Milano-15220 Peach Orchard Rd. S.S. 20904		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u> <u>"</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>na</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>9/25/86</u> 19 <u>83</u> <u>Sept. 26, 1986</u> , that (I) (we) last saw the deceased alive on <u>9/25/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23a. SIGNATURE <u>Thos G. WARD</u>				23b. ATTENDING PHYSICIAN <u>MD</u>		23c. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thos G. WARD</u>				23e. ADDRESS <u>6116 Robinson, Bethesda 20817</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>9-29-1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Burtonsville Montgomery Md.</u>	
24. FUNERAL DIRECTOR <u>Hines/Rinaldi Funeral Home</u>				24b. ADDRESS <u>11800 N.H. Ave., Silver Spring, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 29 1986</u>	
				25b. REGISTRAR'S SIGNATURE			

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20X COAST GUARD

STANDARD

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6
00-19943STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 26393

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Dorothy S. Lehman		9/30/86		10:40 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR	83 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	USA		Montgomery County, MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Suburban	Homemaker	Own Home		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
md	Montgomery	Kensington	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10907 Orleans Way / 20895
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Phillip		Margaret B. Riley		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS	
578-07-9208		Mrs. Margaret L. Mallore, Daughter, Same as		#13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Empyema					1 wk.
DUE TO, OR AS A CONSEQUENCE OF (b) Streptococcus pneumoniae					2 wks
DUE TO, OR AS A CONSEQUENCE OF (c) Hyperosmolar Nonketotic Diabetic Coma					1 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Alzheimer Type Chronic organic					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN STREET COUNTY STATE	
22a. I certify that (1) [this hospital] attended the deceased from 1979 to 9/30/86 that (2) [the] last saw the deceased alive on 9/29/86 and that in (my) [my] opinion death occurred on the date and hour and from the causes stated above. (If true, I did not move the body after death)					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Henry C. Scruggs MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		9/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
HENRY C. SCRUGGS MD		5413 Cedar Lane Bethesda MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		October 2, 1986	Parklawn Memorial Park		CITY OR TOWN COUNTY STATE
					Rockville Maryland
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Avenue, Bethesda, MD.				OCT 03 1986	

CPE

00-10013



0-17731

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26394

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JAMES		F.				LEPLEY, JR.		DATE ESTIMATED		9		8		19		86	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY	
Male		White		June 4, 60		26 YRS.		MONTHS		DAYS		9		8		19	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		2d. HOUR	
Maryland		USA		X								Montgomery County				8P	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Bethesda		Suburban Hospital		Construction		Worker		Maryland		A.A.Co.		Glen Burnie		YES		6 2nd, Ave. Glen Burnie, Md.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
James		Jacqueline M. Turner		No		213-80-5237		Mrs. Jacqueline M. Lepley		Same as 13		PART I DEATH WAS CAUSED BY:					
												IMMEDIATE CAUSE (a) Cranio-cerebral trauma					
												Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
												(b)					
												(c)					
												PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		2:30 PM 9-6-1986		Passenger of auto/auto collision.													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		road		3700 blk. Bel Pre Rd., Wheaton, Montgomery, MD													
22a. I certify that I took charge of the remains described above, held on death resulted from		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
		Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Charles P. Kokes, M.D.		Assistant		9-9-86													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Charles P. Kokes, M.D.		111 Penn St., Balto., MD 21201		Burial		9/12/1986		Cedar Hill Cemetery		Balto.		A.A.Co.		Maryland			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
McCully Funeral Home, 130 E. Fort Ave.		SEP 11 1986		Julia Davidson													

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

C-11131

2000-001-11131

2000-001-11131



11131

00-17111

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 9 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charlotte E. LeVine			2a. DATE OF DEATH MONTH DAY YEAR September 3, 1986			2b. HOUR 2:45a M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1997		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Performer	
13a. STATE New Jersey		13b. COUNTY Burlington		13c. CITY OR TOWN Florence		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST C. T. Hunt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Greice		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 217-09-6996		17. INFORMANT Harry LeVine, Jr. ADDRESS 9915 Overlea Drive Rockville, Maryland 20850					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Central Arteriosclerosis**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Atrial Fibrillation, Generalized Arteriosclerosis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 75 to Sept. 3 19 86 , that (I) (we) lost saw the deceased alive on Aug. 1 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald R. Bucy				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept. 3, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Bucy M.D.				22e. ADDRESS 809 Viers Mill Road Rockville, Maryland 20851			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Florence Burlington New Jersey	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes PA 7557 Wisconsin Avenue Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR SEP 5 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-180668

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 6 3 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MORRIS B Levy			2a. DATE OF DEATH MONTH DAY YEAR 8-29-86			2b. HOUR 6:30 M			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-29-08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Produce Dealer		12b. KIND OF BUSINESS OR INDUSTRY Produce	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 111 University Blvd., West, #1204	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Levy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Becky Levy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-20-4454		17. INFORMANT 1004 Playford Lane Larry Rosenberg Silver Spring, Md. 20901					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 6 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital attended the deceased from 15 July 86 to 29 Aug 86 , that (1) (we) last saw the deceased alive on 29 Aug 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE Dr. H. Rosenberg MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/86	
22d. STYLE NAME (TYPE OR PRINT) HENRI D. BENJAMIN			22e. ADDRESS 7525 Greenway Cir Dr. Greenbelt MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-31-86		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION CITY OR TOWN COUNTY Hyattsville Maryland		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, Md 20852									

BP.

SEP 08 1986

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Clyde W Lick Sr.					2a. DATE OF DEATH MONTH DAY YEAR 9-3-86			2b. HOUR 1:30 A.M.			
3. SEX M		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug 25 / 24		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY W.S.S.O.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1707 Woodman Ave. 20902				
14. FATHER'S NAME FIRST MIDDLE LAST Coleman Lick					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Kearn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWII, Korean, V.N 462-22-4608					16b. SOCIAL SECURITY NO. UWTT, Korean, V.N 462-22-4608		17. INFORMANT ADDRESS Mary Lick 1707 Woodman Ave, Silver Spring Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Refractory Anemia with Excess Blasts										10 weeks	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/1/86 , 19 86 , to 9/3 , 19 86 , that (I) (we) last saw the deceased alive on 9/2/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wesley B. Mason					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/3/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wesley B. Mason					22e. ADDRESS 10500 Summit Ave, Kensington MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-5-86		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery Cheltenham			23d. LOCATION CITY OR TOWN COUNTY STATE Prince Georges Md			
24. FUNERAL DIRECTOR Francis J. Collins Jr.					25a. DATE REC'D. BY REGISTRAR SEP 9 1986						
500 University Blvd. W., Silver Spring, Md 20901					25b. REGISTRAR'S SIGNATURE Jane Davidson-Henderson						

BP

17463

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) George Irving Liff					2a. DATE OF DEATH MONTH DAY YEAR 9/13/86			2b. HOUR 8:45 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 25, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (COUNTRY) Washington, D.C.		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12. CITY OR TOWN OF DEATH Silver Spring		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk (Retired)		15. KIND OF BUSINESS OR INDUSTRY US Post Office	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland		16b. COUNTY Montgomery		16c. CITY OR TOWN Sil. Spg.		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 20902 1111 University Blvd. West	
17. FATHER'S NAME FIRST MIDDLE LAST William Liff					18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Hershowitz				
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					19b. SOCIAL SECURITY NO. WW II 578-20-2101		19c. ADDRESS Silver Spring, Md., 20902 Dorothy Liff; 1111 University Blvd. West		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Embolism Right Leg</u>									
19a. DATE OF OPERATION 9/11/86 + 9/12/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ischemia Right Leg			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 8/30, 19 86, to 9/13, 19 86, that (I) (last saw the deceased alive on 9/13, 19 86, and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (did) (do not) view the body after death.									
22b. SIGNATURE Frank N. Gravino, MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank N. Gravino					22e. ADDRESS 10313 Georgia Ave, Silver Spring, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-15-1986		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 16 1986 Julia Davidson-Rodgers				

BP

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0-17515

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 3 9 9			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHIANG LAN YU LIN				2. DATE OF DEATH MONTH DAY YEAR 9 7 86			
3. SEX Female		4. RACE Chinese		5. DATE OF BIRTH MONTH DAY YEAR January 20, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) An-Tung, China		7b. CITIZEN OF WHAT COUNTRY? China		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lan Geng Shi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		13e. STREET ADDRESS / ZIP CODE 9304 Weathervane Pl. / 20879			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Chung Yun Chiang (Son) Same as # 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>cerebro vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c).							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> 19 <u>86</u> to <u>9/7</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/6/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Alan S. Chambers</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN CHAMBERS				22e. ADDRESS 15225 SHADY GROVE RD ROCKVILLE 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept/8/86		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home Silver Spring, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE <u>Carleen R. Heston</u>	

0-1571

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 0 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pearl O. Lloyd			2a. DATE OF DEATH MONTH DAY YEAR September 23, 1986		2b. HOUR AM PM 8:45 A
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 1 24 1907		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2112 Belvedere Blvd., #4		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. Montgomery Silver Spring			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 2112 Belvedere Blvd. #4 20902
14. FATHER'S NAME FIRST MIDDLE LAST James R. Bailey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Ann Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. N.A.		17. INFORMANT Betty J. Smith 11502 Bucknell Drive, # 104 Wheaton, Md. 20902	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory ARREST DUE TO, OR AS A CONSEQUENCE-OF (b) Metastatic Ovarian Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-2 , 19 85 , to 9-23 , 19 86 , that (I) (we) last saw the deceased alive on 9-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frederick J. Barr M.D.		DEGREE M.D.		22c. DATE SIGNED Sept. 23, 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick J. Barr, M.D.		22e. ADDRESS 2101 Medical Park Dr. #211, Silver Spring Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 25, 86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		24b. ADDRESS 500 University Blvd. West, Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 29 1986	
25b. REGISTRAR'S SIGNATURE John Davidson					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be retained by the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "None", then any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



Form

Question

Form

September 22, 1966

COTTON FIBER

Handwritten signature or initials.

0-17682

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JEANETTE LOEB			2a. DATE OF DEATH MONTH 9 DAY 7 YEAR 86			2b. HOUR 6:15 P.M.													
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 7 DAY 30 YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.													
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK			12b. KIND OF BUSINESS OR INDUSTRY Federal Gov't.										
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6015 Montrose Road (20852)										
14. FATHER'S NAME FIRST Meyer MIDDLE Loeb LAST Loeb				15. MOTHER'S MAIDEN NAME FIRST Leah MIDDLE Spanier LAST Spanier				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 160-30-4470				17. INFORMANT ADDRESS 20016 Marion Fournier; 5429 Conn. Avenue, N.W.; Wash., DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 8/15 , 19 86 , to 9/8 , 19 86 , that (I) (we) last saw the deceased alive on 9/5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Alan S. Chanaler				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/8/86											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN S. CHANALER				22e. ADDRESS 15225 SHADY GROVE RD ROCKVILLE MD															
23a. BURIAL, CREMATION, REMOVAL RECEIVED Burial				23b. DATE 9/9/86		23c. NAME OF CEMETERY OR CREMATORY Wash. Hebrew Cong. Cemetery; Washington, D.C.				23d. LOCATION CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852																			
25a. DATE REC'D. BY CLERK SEP 10 1986																			
25b. REGISTRAR'S SIGNATURE Julia Darden-Randey																			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-17885

NOV 10 1963



SEP 10 1963

00-17593

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Louise Bailey Long						2a. DATE OF DEATH MONTH DAY YEAR 9/6/86		2b. HOUR MIN. 12:45 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 16 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park, Maryland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington at Venice Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Burtonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #2 Perrywood Court 20730			
14. FATHER'S NAME FIRST MIDDLE LAST George Byrd				15. MOTHER'S MAIDEN NAME FIRST LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-10-8092		17. INFORMANT Mrs. Sylvia B. McConkey (Daughter) Same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left cerebral hemisphere stroke DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12 Aug 1986 to 6 Sept 1986 , that (I) (we) last saw the deceased on 6 Sept 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6 Sept 86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz		22e. ADDRESS 1110 New Hampshire Ave SE Apt 20904									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/9/1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Vernon, Somerset, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, P.A., Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SITWARE LONG			2a. DATE OF DEATH MONTH DAY YEAR 9 13 86			2b. HOUR 9:55 P.M.					
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 3 1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO MD.					
10. CITY OR TOWN OF DEATH S. SPRINGS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY G.S.A.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) DC STATE			13b. COUNTY WASH.		13c. CITY OR TOWN WASH.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 615 R.I. AVE N.W. 99899		
14. FATHER'S NAME FIRST MIDDLE LAST William LONG			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delha WOOD			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. U.	
17. INFORMANT DELHA HAIRSTON (NIECE)			ADDRESS 1730-SARATOGA AVE N.E. # 2								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE, RENAL FAILURE, HEPATIC FAILURE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from SEPT. 10, 19 86, to SEPT. 13, 19 86, that (1) (we) last saw the deceased alive on SEPT. 13, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE William H. Silverman MD						DEGREE MD			22c. DATE SIGNED 9-14-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. SILVERMAN						22e. ADDRESS 6111 EXECUTIVE BLVD. ROCKVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 17-SEPT-86		23c. NAME OF CEMETERY OR CREMATORY HARMONY			23d. LOCATION CITY OR TOWN COUNTY STATE Landover FGC MD			
24. FUNERAL DIRECTOR NAME MODERN FUNERAL Home						25a. DATE REC'D. BY REGISTRAR SEP 18 1986			25b. REGISTRAR'S SIGNATURE na Davidson-Ripstein		

MEDICAL CERTIFICATION



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00-17920

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 4 0 4			
FOR STATE REGISTRAR Howard C. Looney				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HOWARD C. LOONEY				2a. DATE OF DEATH MONTH DAY YEAR 9 9 86		2b. HOUR 8 45 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY F.C.C.	
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER ROBERT LOONEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA --- SALMOND		13e. STREET ADDRESS / ZIP CODE 7609 Cayuga Ave. 20817			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-44-0333		17. INFORMANT ADDRESS Harriet G. Looney Same as item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 7 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease with Severe Congestive Heart Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 8-30-1984 to 9-9-1986 that (I) (we) last saw the deceased alive on 9-8-1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen W. DeJeter, M.D.				DEGREE M.D.		22c. DATE SIGNED 9-9-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEJETER, M.D.				22e. ADDRESS 6719 WILSON LANE, BETHESDA, MD 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/13/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD	
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE Davidson	

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May 16, 1916

Montgomery

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00-17908

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be preserved within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma ORR LOUDEN			2a. DATE OF DEATH MONTH DAY YEAR 9 11 84			2b. HOUR 9³⁵ P^M	
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 13 98		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST William John Orr				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Shaw			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 266-76-9752		17. INFORMANT ADDRESS Frances Bird Loudon, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death - presumably cardiac - DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease - DUE TO, OR AS A CONSEQUENCE OF (c) 10+ years -							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10+ years -
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CVA - with right hemiplegia & aphasia - 1979							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 1972 , to 9/11 1984 , that (I) (we) last saw the deceased alive on 8/6 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If so, add: when view the body after death.)							
22b. SIGNATURE Richard M. Huffman M.D.				DEGREE M.D.		22c. DATE SIGNED 9/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. HUFFMAN M.D.				22e. ADDRESS 3310 NEW MEX AVE., WASH. D.C. 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Sept. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Oakwood Memorial Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Saginaw, Michigan	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes				25a. DATE REC'D. BY REGISTRAR SEP 15 1986			
25b. REGISTRAR'S SIGNATURE John A. Pumphrey							

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00-19896

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26400

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HERSCHEL H. LOWE, JR. <i>Herschel H Lowe</i>			2a. DATE OF DEATH MONTH DAY YEAR 9 30 86			2b. HOUR 1 40 M			
3. SEX male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 6 24 32		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interior Design		12b. KIND OF BUSINESS OR INDUSTRY Quality Inn	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1817 Briggs Road 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Herschel H. Lowe, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Stewart				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-40-9521		17. INFORMANT ADDRESS Faye Lowe, Wife 1817 Briggs Road Silver Spring, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Carcinoma metastatic to pleura, breastAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 mo

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 72 to 30 Sept 19 86 , that (I) (we) last saw the deceased alive on 30 Sept 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>IRA N. TUSLIN</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA N. TUSLIN				22e. ADDRESS 8830 Cameron Street Silver Spring, Maryland 20910			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/1/86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home NAME ADDRESS 11800 New Hampshire Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 03 1986			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified and a postmortem examination required.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR MIN		
John LeRoy Luckett						2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR MIN		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.		
M			W			Aug 2 1960			90 YRS.			MONTHS DAYS HOURS MIN.		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA			WIDOWED			DIVORCED			Montgomery MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring			Holy Cross Hosp			Clerk			Patent Office					
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS					
Md Mont			Bethesda			YES NO			6503 Carnegie Drive			20817		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
John B. Luckett			Caroline Clements			YES NO			219-42-4147			Alfred Wardell Friend Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:														
888 IMMEDIATE CAUSE (a)			Acute Myocardial Dis											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last			(b) Chronic Myocardial Dis											
			(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
Fracture L Hip														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
None						YES NO								
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION								
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION								
22a. I certify that I took charge of the remains described above, held on death resulted from:			Autopsy Inspection Inquiry			and in my opinion								
Natural causes Accident Suicide Homicide Undetermined manner														
ACTUAL SIGNATURE			TITLE (SPECIFY)			MEDICAL EXAMINER			DATE SIGNED					
John S. Rogers, M.D.			1919 Seminary Road Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION					
Burial			Oct 1, 1986			Cedar Hill Cemetery			Suitland Pr. Geo. Maryland					
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Francis J. Collins, Jr.			OCT 03 1986											
500 University Blvd., W. Silver Spring, Md.														

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. THIS CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17
(VR A15 ME (5))

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1017 Remington Arms Silver Spring, Md.

John S. Rogers, M.D.

1017 Remington Arms Silver Spring, Md.

1017 Remington Arms Silver Spring, Md.

1017

Francis J. Collins, Jr.
1017 Remington Arms Silver Spring, Md.

00-18493

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon parts, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

99999

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 4 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD JOSEPH LYNCH			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 16 1986			2b. HOUR A M 6:00 A			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 28 1930		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
13a. STATE VIRGINIA		13b. CITY OR TOWN STERLING		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10 CHEVAL COURT 22170		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH LYNCH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH KELLY			17. INFORMANT ADDRESS EDITH LYNCH, 10 CHEVAL COURT, STERLING, VA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1950-1970 032-22-3944							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 23, 1986 , to SEPTEMBER 16, 1986 , that (I) (we) last saw the deceased alive on SEPTEMBER 16, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>V. L. Waker</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9-16-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.G. LITAKER, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (RECORD) BURIAL, REMOVAL		23b. DATE 9/19/86		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN ARLINGTON VA			
24. FUNERAL DIRECTOR NAME J. BERKLEY GREEN, HERNDON, VIRGINIA				25a. DATE REC'D. BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

0-10403



00-19371

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26409

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Louise E. Lyons			2a. DATE OF DEATH MONTH 9 DAY 19 YEAR 86		2b. HOUR 10:26 PM
3. RACE Female		4. RACE cau.	5. DATE OF BIRTH MONTH 3 DAY 13 YEAR 07		6. AGE (IN YEARS (LAST BIRTHDAY)) 79 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District of Columbia		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH Wheaton			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Con + Nursing Home D.C. Payroll		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.C. Recreation D.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST Thomas MIDDLE F. LAST Quinlan		15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE V. LAST Harrison		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
17. SOCIAL SECURITY NO. 578-40-7116		18. INFORMANT ADDRESS Sarah L. Bland same as # 13			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from 29 AUG 19 86 to 19 SEPT 19 86 , that (I) (was) last saw the deceased alive on 19 SEPT 19 86 , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) not view the body after death.					
22a. SIGNATURE Walter E. Gooch MD		22b. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD		22c. DATE SIGNED 20 AUG 1986	
22d. ADDRESS 2309 SHOREFIELD RD WHEATON MD		23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23a. DATE Sept. 24, 86		23b. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23c. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Georges Md.	
24. FUNERAL DIRECTOR'S NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE Francis J. Collins, Jr.	

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TO HOSPITAL, NURSING HOME, OR OTHER INSTITUTION: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-19895

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 6 4 1 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH P. MACEIRA			2a. DATE OF DEATH MONTH DAY YEAR Sept. 30 1986			2b. HOUR 3:12p ^M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 15, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spain		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 452 Girard Street				12a. USUAL OCCUPATION (WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 452 Girard Street/20877	
14. FATHER'S NAME FIRST MIDDLE LAST Severino Maceira					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Tiboe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 195-20-7519		17. INFORMANT ADDRESS Lenora Kay Maceira-wife-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Cell Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5½ years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from September 5, 19 86, to Sept. 30, 19 86, that (I) (we) last saw the deceased alive on September 5, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Albert E. Rolle, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-30-1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert E. Rolle, M.D.						22e. ADDRESS 3800 Reservoir Rd., N.W.D.C.20007			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-3-1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.		
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home						11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR OCT 03 1986	
25b. REGISTRAR'S SIGNATURE John Davidson									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

ve been processed by the Division of Vital Records
f you have sent birth certificates to DVR which are
is or any previous list, please contact Ms. Faye
764-3187 or Ms. Marisa Wilson at 410-225-5937.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 4 1 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Kathryn Hargett Mack				2a. DATE OF DEATH MONTH DAY YEAR 9 30 86		2b. HOUR 5:20A _M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR OCT. 12, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Albert B. Hargett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie V. Albaugh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-40-4871		17. INFORMANT ADDRESS Rev. Robert Mack-3326 Gilman Ter., Balt.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic Heart Disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 wk. 5 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>4-23</u> , 19 <u>80</u> , to <u>9-30</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Harold F. McCann</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>9-30-86</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HAROLD F. MCCANN</u>				22c. ADDRESS <u>4362-26th A N ARLINGTON, VA</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>SEP. 30/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>METROPOLITAN CREMATORY, ALEXANDRIA, VA.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>22207</u>	
24. FUNERAL DIRECTOR NAME <u>HYSONG CO., INC.-1300 N ST., NW</u>				25a. DATE REC'D. BY REGISTRAR <u>Oct 01 1986</u>			
ADDRESS <u>WASH., DC</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

00-10847



33
00-18674

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 1 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FLORENCE L MACON			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 15 1986		2b. HOUR 3:45 P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 8, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9101 2ND AVE SILVER SPRING, MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER	12b. KIND OF BUSINESS OR INDUSTRY ITALY SCHOOL
13a. STATE NONE		13b. CITY OR TOWN WASH. D.C.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS, ZIP CODE 3133 CONN. AVE. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK C. MURPHY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH NEWELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-62-9542		17. INFORMANT ATTORNEY ADDRESS 2933 GARFIELD TOWR WASH. D.C. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) acute bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying illness last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ASHD; ASCVD E OBS (advanced); Ca breast					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-13 1986 to 9-15 1986 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 9-15 1986 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE George Stokrova				22c. DATE SIGNED 9-15-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL		23b. DATE SEPT. 19, 1986	23c. NAME OF CEMETERY OR CREMATORY WEST POINT CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WEST POINT, N.Y.
24. FUNERAL DIRECTOR NAME James E. DeVol		24b. FUNERAL HOME DEVOL FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR SEP 19 1986	25b. REGISTRAR'S SIGNATURE John L. ...

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret Maly			2a. DATE OF DEATH MONTH DAY YEAR September 11, 1986		2b. HOUR 1:05A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 12, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 75
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 18 Treworthy Road / 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Schuster			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Doleschal		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 064-18-5374		17. INFORMANT Mrs. Marthe Corvelli, Daughter, Same as item #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Disease	5 Years
	DUE TO, OR AS A CONSEQUENCE OF (c)	
	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 79 to Sept. 11, 19 86 , that (I) (we) last saw the deceased alive on Sept 8, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Alexander C. Chester</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Sept. 11, 1986
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alexander C. Chester, M.D.		22e. ADDRESS 3301 New Mexico Ave., N.W. Washington, D.C. 20016	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 15, 1986	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Bronx New York
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, MD.		25a. DATE REC'D. BY REGISTRAR SEP 15 1986	25b. REGISTRAR'S SIGNATURE <i>Davidson-Henderson</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

100-15001



00-17201

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 4 1 4

REG. NO.

1. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST WILLIAM MALBECK Jr.			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1 1986		2b. HOUR 6:10 A		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 30 1908		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 78 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
13a. STATE MARYLAND		13b. CITY OR TOWN ST. MARY'S		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE P. O. BOX 51 20674	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HENRY MALBECK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE EMALINE BODIFORD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1925-1946		17. INFORMANT ADDRESS WILLIAM A. MALBECK, 41 BERRY HILL ROAD,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 4 , 19 86 , to SEPTEMBER 1 , 19 86 , that (I) (we) last saw the deceased alive on SEPTEMBER 1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M. Pierdinock</i>				DEGREE MD		22c. DATE SIGNED 2 Sept 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. PIERDINOCK, LCDR, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/4/86		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY, LEONARDTOWN, MD.				25a. DATE REC'D. BY REGISTRAR SEP 5 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Hopkins</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

00-15561

00-19089

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 6

4 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>LAWRENCE B. MALONEY, Jr.</u>			2a. DATE OF DEATH MONTH <u>9</u> DAY <u>16</u> YEAR <u>86</u>			2b. HOUR <u>3 AM</u>					
3. SEX <u>Male</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH <u>8</u> DAY <u>10</u> YEAR <u>24</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>62</u> YRS		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co.</u> MD.					
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Real Estate Broker</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Director Uniroof, Inc.</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Silver Spring</u>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>1212 Woodside Parkway 20910</u>		
14. FATHER'S NAME FIRST <u>Lawrence</u> MIDDLE <u>B.</u> LAST <u>Maloney, Sr.</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Elsie</u> MIDDLE <u>Marie</u> LAST <u>Cavey</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u> 16b. SOCIAL SECURITY NO. <u>WW II 474-14-0383</u>					
17. INFORMANT <u>Son</u>			ADDRESS <u>1107 Frederick Ave. Salisbury, Md. 21801</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure with arrest.</u> DUE TO, OR AS A CONSEQUENCE OF <u>Septic emboli to the brain</u> DUE TO, OR AS A CONSEQUENCE OF <u>Bacteremia - Endocarditis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Septic emboli to the brain - Calcification</u>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>231 University Blvd. S. Spring Md.</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/12/86</u> to <u>9/15/86</u> , that (I) (we) last saw the deceased alive on <u>9/15/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE <u>M. A. Rodriguez</u> DEGREE			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. H. Rodriguez</u>			22e. ADDRESS <u>231 University Blvd. S. Spring Md.</u>			22f. DATE SIGNED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>SEP 20 1986</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Sep. 20, 1986</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring Montgomery Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins, Jr.</u>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
500 University Blvd., W. Silver Spring, Md.											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as (b) or (c), the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please return completed pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
Nicholas		N				Marchetti		9-1-86		1:45pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		MONTH DAY YEAR 5 19 12		74 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		United States				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital						Builder		Development	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Bethesda		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7378 Westlake Terrace		20817	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS			
John				Constance				Favaccia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
No				182-10-6930		Adelaide Marchetti, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>arteriosclerotic heart DIS</u>										<u>YEARS</u>	
(c) <u>METASTATIC ADENOCARCINOMA</u>										<u>2 YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (b) this hospital attended the deceased from 9/1/86 to 9/1/86 that (1) I saw the deceased alive above, (2) I did not view the body after death.				19 86				19 86			
22b. SIGNATURE <u>Morton W. Skapin</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/2/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton W. Skapin				22e. ADDRESS 5225 Pook St. 11 Rd Bethesda							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Entombment				4, 1986		Gate of Heaven		Silver Spring, Maryland			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814 PA											
DATE REC'D. BY REGISTRAR SEP 5 1986								REGISTRAR'S SIGNATURE John Davidson			

00-15103

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8026417

1- FOR
STATE
REGISTRAR

REG. NO.

0-19674

1. DECEASED NAME (TYPE OR PRINT) HELEN C MARSDEN			2a. DATE OF DEATH MONTH DAY YEAR 9 27 86		2b. HOUR 8 AM
3. SEX female	4. RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 11 1899		6. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health CARE Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Cox			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Skinner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 56 7373		17. INFORMANT ADDRESS Derwood, Md. 20855 Deroy W. Marsden, 7708 Yellowstone Way	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) A.S.H.D. - (Nephrosclerosis) DUE TO, OR AS A CONSEQUENCE OF (c) Gen'l Atherosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Second 3 weeks 4 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 75 to Sept. 27 1986 , that (I) (most) saw the deceased alive on Sept. 17 1986 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death.					
22b. SIGNATURE Jack Schumacher M.D.				22c. DATE SIGNED 9-27-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher				22e. ADDRESS 105 Russell Ave, Gaithersburg	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE Sep. 28, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION (CITY OR TOWN) Alexandria,		COUNTY Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes,				25a. DATE REC'D. BY REGISTRAR OCT 01 1986	
ADDRESS P.A. 300 W. Montgomery Av., Rockville, Md. 20850				25b. REGISTRAR'S SIGNATURE	

0-10874



0-17461

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 1 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret A. Marshall			2a. DATE OF DEATH MONTH DAY YEAR September 1 1986		2b. HOUR 9:52a _M	
3. SEX F	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 27 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2667 Cory Terrace		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Beauty Parlor	
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2667 Cory Terrace 20902		
14. FATHER'S NAME FIRST MIDDLE LAST Robert White			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mae White			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-09-6141		17. INFORMANT ADDRESS Jeanne Crow (daughter) 2629 Cory Terrace		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LIVER METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF RECTUM</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 1 1/2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 6</u> , 19 <u>85</u> , to <u>Sept 1</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Aug 26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Hubert J. Alpert</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/2/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert J. Alpert M.D.		22e. ADDRESS 8630 FENTON ST #230 Silver Spring Md 20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 4, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Md
24. FUNERAL DIRECTOR NAME Francis J. Collins Jr.		25a. DATE REC'D. BY REGISTRAR SEP 9 1986		25b. REGISTRAR'S SIGNATURE		
500 University Blvd. W., Silver Spring, Md 20901						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8626417			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT S. MASON				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR Sept. 22, 1986 M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR NOV. 22, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md. 13b. COUNTY Montg. 13c. CITY OR TOWN Germantown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME (FIRST MIDDLE LAST) Robert M. MASON				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Annie M. Noland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-48-9681		17. INFORMANT (NAME AND ADDRESS) Annie Mason (mother) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) prostatic carcinoma							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/21/86 19 to 9/22/86 19, that (I) (we) lost saw the deceased pass on 9/22/86 19, and that (my) (our) opinion death occurred on the date and hour and from the causes stated (above) (below) (did) (did not) view the body after death.							
22b. SIGNATURE (TYPE OR PRINT) Pasqual Perrino				DEGREE MD		22c. DATE SIGNED 9/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pasqual Perrino, M.D.				22e. ADDRESS 15 E. Deer Park Dr., Gaithersburg, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-25-86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St. Rockville, MD 20850			
DATE REC'D BY REGISTRAR SEP 29 1986				REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Robert" and "M." are faintly visible.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Ralph John Mathis				2a. DATE OF DEATH MONTH 9 DAY 14 YEAR 86	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Nov. DAY 24 YEAR 1907	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST Lloyd MIDDLE Columbus LAST Mathis		15. MOTHER'S MAIDEN NAME FIRST Avas MIDDLE Isabelle LAST Haynes		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Upholsterer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 234-05-7795		17. INFORMANT 701 Mapleton Drive Rockville, Md. Margaret Mathis (wife) 20850	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Essential Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-13 , 19 86 , to 9-14 , 19 86 , that (I) (we) last saw the deceased alive on 9-13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D.L. Bucy / SN Jones				22c. DATE SIGNED 9-14-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.L. Bucy / SN Jones				22e. ADDRESS 809 Ueirs Mill Rd. Rockville	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park	
23d. LOCATION Rockville Maryland		23e. STATE Md.		23f. COUNTY Montgomery	
24. FUNERAL HOME Ryson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR SEP 19 1986	
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S NAME	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8626421

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JOHN J MATIMORE			2a DATE OF DEATH MONTH DAY YEAR 9 15 1986			2b HOUR 9⁵⁰ A.M.			
3 SEX MALE		4 RACE CAUCASION		5 DATE OF BIRTH MONTH DAY YEAR 12 29 94		6 AGE (IN YEARS (LAST BIRTHDAY)) 91		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.			
10 CITY OR TOWN OF DEATH ROCKVILLE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD NSG CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. SALES MAN		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MARYLAND				13b COUNTY MONTGOMERY		13c CITY OR TOWN CATHERSBURG		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN J MATIMORE				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRIDGET GILHOOLEY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 084-09-3069		17 INFORMANT ADDRESS			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RIGHT UPPER LOWER LOBE PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**Acute**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from FEBRUARY 19 86 , to Sept 15 19 86 , that (I) (we) last saw the deceased alive on Sept 15 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE Thomas E. Dole		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED SEP 15, 1986	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dole M.D.		22e ADDRESS 17904 GEORGIA AVENUE OLNEY, MARYLAND 20822					

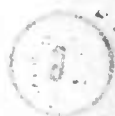
23a BURIAL, CREMATION, REMOVAL CREMATION		23b DATE 9/16/86		23c NAME OF CEMETERY OR CREMATORY LEECREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.	
24 FUNERAL DIRECTOR NAME GARTNER-SANDISON GAITHERSBURG				25a DATE REC'D. BY REGISTRAR SEP 19 1986		25b REGISTRAR'S NAME John H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "b", show any injury, or other traumatic event, the medical examiner must be notified at once.

13831-01



CARTER SANDISON CARTER SANDISON
Rt. E. BARNARD
Sept 1914
WASHINGTON D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked for items 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823,

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THELMA MATTHEWS		2a. DATE OF DEATH 9 22 '86		2b. HOUR 3:45 M	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 6 DAY 1 YEAR 22	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? US		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. 	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Housewife	
13a. STATE Md.		13b. COUNTY Montg		13c. STREET ADDRESS / ZIP CODE 1611 April Lane / 20904	
14. FATHER'S NAME FIRST MIDDLE LAST 		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
17. SOCIAL SECURITY NO. 212-82-9546		18. INFORMANT FRANK MATTHEWS (Husband)		19. ADDRESS Somers #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left hemisphere stroke DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				*APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs +	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITIONS GIVEN IN PART 1: Acute anterolateral myocardial infarction - Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 9/21 19 79 , to 9/22 19 86 , that (1) we last saw the deceased alive on 9/21 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (I) did not view the body after death.					
22b. SIGNATURE George S. Kenton MD				22c. DATE SIGNED 9/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. KENTON				22e. ADDRESS 10620 Georgia Ave Silver Spring, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-26-86		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.	
23d. LOCATION CITY OR TOWN Sandy Spring, MD		23e. COUNTY Montg.		23f. STATE MD	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR SEP 23 1986	
25b. REGISTRAR'S SIGNATURE John J. [Signature]					

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010-18056

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 6 4 2 3
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Frank O. Mayhew		Male		White	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
May 18 1909		77 YRS.		Montgomery MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
W. Va.		U.S.A.			
9. CITY OR TOWN OF DEATH		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rockville		SHADY GROVE ADVENTIST		Ret'd Machinist	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13b. CITY OR TOWN	
Md.		Montgomery		Gaithersburg	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.	
Ira M. Mayhew		Lucretia Garfield Clark		234-03-5957	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT	
No		234-03-5957		Wm. R. Mayhew	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		1 1/2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (b)		1 1/2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 86 to 8/29 86, that (I) (we) last saw the deceased alive on 8/29 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. DATE SIGNED		22c. DATE SIGNED	
22a. SIGNATURE		22b. ADDRESS		22c. DATE SIGNED	
Dennis Friedman		15225 SHADY GROVE RD, Rockville MD		8/29/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9/4/86		Fort Lincoln Cemetery	
24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT)		24. FUNERAL DIRECTOR'S ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Gartner Sandison F. H.		316 E. Diamond Ave. Gaithersburg, Md. 20877		SEP 08 1986	
25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
Julia Sandison-Kandish		Julia Sandison-Kandish		Julia Sandison-Kandish	

BP

W. Va. Montgomery, Alabama 211 Russell Ave. 1902
Rockville Montgomery, Alabama 211 Russell Ave. 1902
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted before signing.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 2 6 4 2 4	
1. DECEASED NAME (TYPE OR PRINT) JEAN S. MAYHEW						7a. DATE OF DEATH MONTH DAY YEAR AUGUST 9 1986		7b. HOUR 1800 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 15 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		8. UNDER 1 YEAR MONTHS DAYS 80			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Nurse		12b. KIND OF BUSINESS OR INDUSTRY Prince Geo. Hospital			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 211 Russell Ave. #208 20760			
14. FATHER'S NAME FIRST MIDDLE LAST Steven S. Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maud M. Mixer				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -			
16b. SOCIAL SECURITY NO. 577-42-7328				17. INFORMANT William R. Mayhew				ADDRESS 65 C Ridge Road, Greenbelt, Md. 20770			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Pulmonary fibrosis & resp. failure DUE TO, OR AS A CONSEQUENCE OF (c) 3 wks										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Diabetes mellitus, Anemia											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				70a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
72a. I certify that (1) (this hospital) attended the deceased from Aug 28 , 19 84 , to Aug 9 , 19 86 , that (1) (we) last saw the deceased alive on Aug 9 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
72b. SIGNATURE James R. Moore Jr.				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		72f. DATE SIGNED 8-9-86	
72d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr.				72e. ADDRESS 207 Brookes Ave Gaithersburg Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 12, '86		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Geo. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Donald B. Sandison 316 E. Diamond Ave., Gartner Sandison F.H. Gaithersburg, Md. 20877				25a. DATE REC'D. BY REGISTRAR AUG 14 1986				25b. REGISTRAR'S SIGNATURE James R. Moore Jr.			

BP

80

Jan. 15, 1902

White

White

U.S.A.

U.S.A.

Localities

Montgomery, California, 1 mi. S. of Inglewood Ave. 1902

Staves

2

Colts

Hand

577-12-7328

William E. Rogers

57 E. 12th St.,
New York, N.Y.

Jan. 15, 1902

White

San Francisco, Cal.
310 E. Market St.
Jan. 15, 1902

2
0-15328

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 2 5

1- FOR
STATE
REGISTRAR

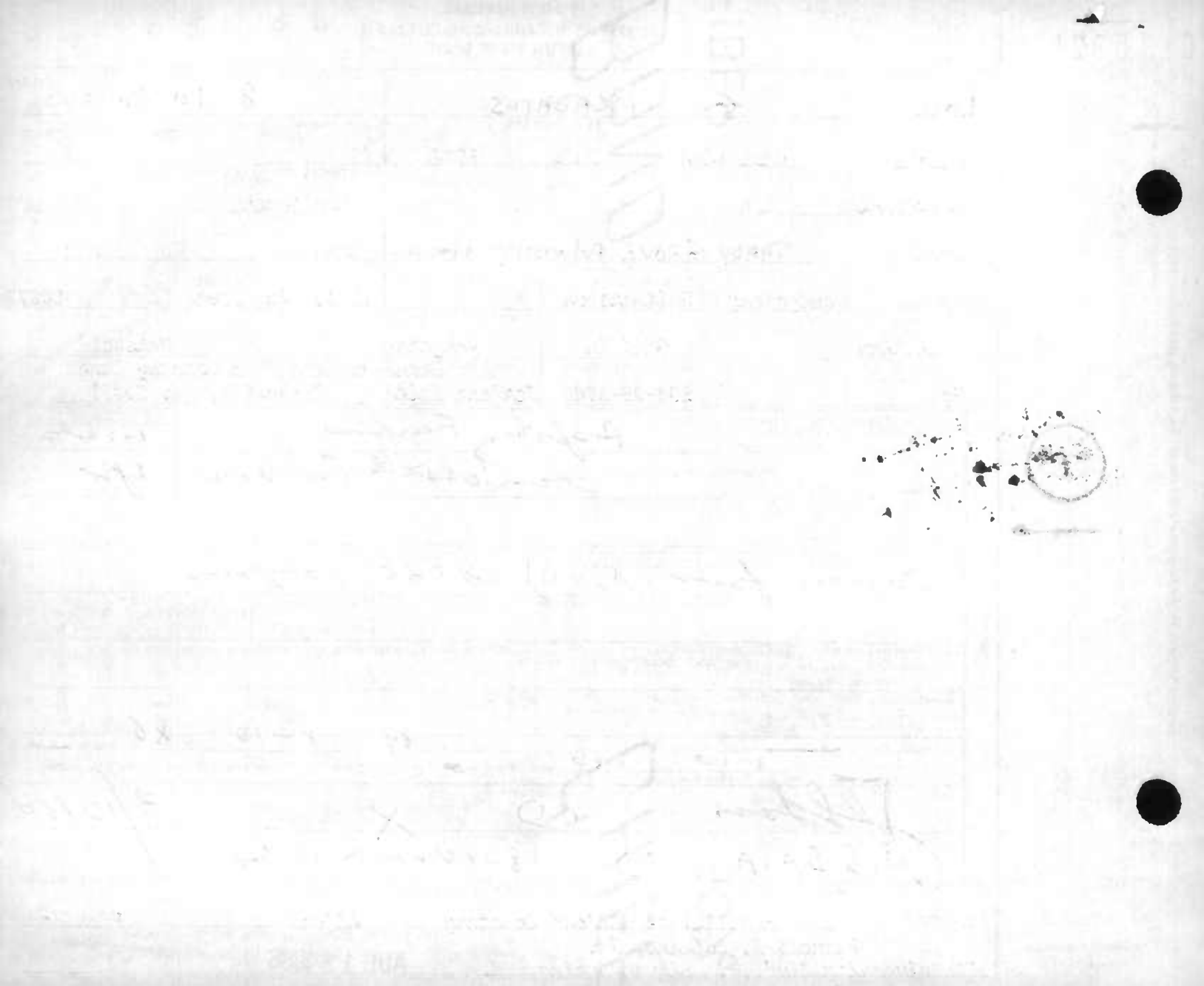
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lou G. McADAMS			2a. DATE OF DEATH MONTH DAY YEAR 8 10 86		2b. HOUR NOON 1200 M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 8, 1904		6. AGE (IN YEARS LAST BIRTHDAY) YRS 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Food Store	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Griffin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Marshall		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232-05-6900	
17. INFORMANT Granddaughter		ADDRESS 3 Dorothy Lane		CITY OR TOWN Rockville, Md.		STATE 20851	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) hypertension						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Coronary failure (ASHD) old TBC, osteoporosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-10-86 , 19 84 , to 8-10-86 , that (I) (was) last saw the deceased alive on 8-10-86 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.							
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.S. SAIA		22e. ADDRESS 809 Views Mill Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE AUG. 11, 1986		23c. NAME OF CEMETERY OR CREMATORY Alford Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Alford Florida	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR AUG 13 1986		25b. REGISTRAR'S SIGNATURE [Signature]			
500 University Blvd., W. Silver Spring, Md.							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHRYN A. McASKILL				2a. DATE OF DEATH MONTH DAY YEAR 9/12/86 09 12 86			
3. SEX Female		4. RACE CAUS.		5. DATE OF BIRTH MONTH DAY YEAR 3 21 03		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ex. Secretary		12b. KIND OF BUSINESS OR INDUSTRY Bethlem. Steel	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick		15. MOTHER'S MAIDEN NAME FIRST LAST Kathryn Gill		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 577-38-7657		17. INFORMANT ADDRESS Mary L. Pijar same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordic Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Mania							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 13, 19 84 , to present , 19 86 , that (I) (we) last saw the deceased alive on Aug. 26, 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE John B. Umhauer MD				22c. DATE SIGNED 9/12/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS John B. Umhauer MD 8805 Cony. Ave. Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring Md.				25a. DATE REC'D. BY REGISTRAR SEP 18 1986		25b. REGISTRAR'S SIGNATURE	

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00-15840
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR AKA Jeannie B. McAtee					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Jeannia W. Mc Atee					2a. DATE OF DEATH MONTH DAY YEAR 8 16 86 2b. HOUR 9:50 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 23 91		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13e. STREET ADDRESS / ZIP CODE 6530 Democracy Blvd. 20817			
14. FATHER'S NAME FIRST MIDDLE LAST George Whitecotton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lily McAtee				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 578-62-0293		17. INFORMANT ADDRESS Camden R. McAtee, Jr. 428 Northwest Dr. Silver Spring, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intractable congested heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.H.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (his) hospital attended the deceased from _____, 19 <u>82</u> , to <u>August 16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>August 8, 1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. Blaine Fitzgerald, MD</u>					22c. DATE SIGNED <u>8/16/86</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, MD					22e. ADDRESS 8218 WI Ave. Bethesda, MD 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/19/86		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC					25a. DATE REC'D. BY REGISTRAR AUG 20 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

Figure 1

(continued)

DATE: 11-11-1964

00-17910

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Arthur J. McDermott			2a. DATE OF DEATH MONTH DAY YEAR September 11, 1986		2b. HOUR pm 2:45 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 31, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proprietor	12b. KIND OF BUSINESS OR INDUSTRY Hardware	
13a. STATE Maryland		13b. COUNTY Calvert	13c. CITY OR TOWN Huntington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Neeld Estate / 20639
14. FATHER'S NAME FIRST MIDDLE LAST Not Available		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available		16. ADDRESS 1020 Neal Drive	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578 48 5276		17. INFORMANT (son) William Dennis McDermott Rockville, Md. 20850	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from October 29, 1978, to Sept. 11, 1986, that (I) (we) last saw the deceased alive on August 26, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Walter E. Goozh, M.D.</i>		22c. DATE SIGNED September 11, 1986		22d. ADDRESS 20902	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Walter E. Goozh, M.D.		22f. ADDRESS 2309 Shorefield Road, Wheaton, MD		22g. DATE SIGNED September 11, 1986	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 15, 1986	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland	23e. DATE REC'D. BY REGISTRAR SEP 15 1986
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey P.A., 300 W. Montgomery Ave., Rockville, Md.		24b. ADDRESS Rockville, Md.		25a. REGISTRAR'S SIGNATURE <i>John A. Swindler</i>	

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2000 COLLEGE HALL

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DHMH - 16 DOM 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JAMES EDWARD MC KINLEY			2a. DATE OF DEATH MONTH 09 DAY 26 YEAR 86		2b. HOUR 3:15p M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 12 DAY 03 YEAR 37		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS	IF UNDER 1 YEAR MONTHS 00 DAYS 00
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GOVERNMENT		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE D.C.	13b. COUNTY D.C.	13c. CITY OR TOWN WASHINGTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1035 MICHAGAN AVE, N.E. 20017	
14. FATHER'S NAME FIRST ROOSEVELT MIDDLE NMN LAST DYER			15. MOTHER'S MAIDEN NAME FIRST ELLA MIDDLE MAE LAST MC KINLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1954 to 1975		17. INFORMANT WIFE ALIDA TWANA MCKINLEY/SAME	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST/ASYSTOLE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	(b) HEMALYTIC ANEMIA	
	(c) DUE TO, OR AS A CONSEQUENCE OF	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **16 SEPT**, 19 **86**, to **26 SEPT**, 19 **86**, that (I) (we) lost saw the deceased alive on **26 SEPT**, 19 **86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Robert P. Dolan MD	DEGREE	22c. DATE SIGNED 9/28/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT P. DOLAN, LT, MC, USNR	22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-2-86	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN Ft. Myer, Va. COUNTY STATE
24. FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St. N.E., D.C. 20017		25a. DATE REC'D. BY REGISTRAR SEP 30 1986	

25b. REGISTRAR'S SIGNATURE
John Davidson

00421-00

Handwritten signature or initials

00-18267

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Jorge		A		Mendez				9-10-86		19		10		86		4:13 PM					
3. SEX		4. RACE		DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		Cauc		11 2 10		75						9 10 19		10		04:13					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Peru		Peru		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		Montgomery County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY															
Bethesda		Suburban Hospital		Retired		Peruvian															
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD		MONTGOMERY		LAYTONSVILLE		YES		5924 GRIFFITH RD												20879	
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST											
Alejandro				Mendez		Asuncion				(Unknown)											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT																	
No		None		Maximo Pierola		5924 Griffith Rd.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CARDIORESPIRATORY FAILURE SUBDURAL		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
8809				DUE TO, OR AS A CONSEQUENCE OF				10-12 HRS													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		FALL DOWN STEPS		13 HRS													
				(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				ETANOLISM																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?													
								YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED																	
8 P.M.		9 9 1986		FELL DOWN 18-20 STEPS																	
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION																	
NOT WHILE AT WORK		HOME		5924 GRIFFITH RD		Laytonville		MONT		MD											
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion															
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner											
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED													
Francis C. Mayle		DEPT.						9/10/86													
EXAMINER'S NAME		ADDRESS																			
(TYPE OR PRINT)		800 Wisconsin Ave		Bethesda Rd																	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION															
Burial		9/13/86		Parklawn Memorial Park		Rockville, Maryland															
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
NAME		SEP 17 1986		John Decker																	
Tyson Wheeler Funeral Home, Inc.																					
1331 Rockville Pike, Rockville, Maryland 20852																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

00-10287

Wentworth

John

Wentworth County

Wentworth County

WENTWORTH COUNTY

WENTWORTH COUNTY

00-17520

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, the medical examiner is to examine at site.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CHARLES MERICAN					2a. DATE OF DEATH MONTH DAY YEAR September 7, 1986			2b. HOUR 3:00pm			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12000 Old Georgetown Rd. #400N				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wholesaler		12b. KIND OF BUSINESS OR INDUSTRY Seafood			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Merican					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Spielman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 216 32 0852		17. INFORMANT ADDRESS Geraldine Polinger 3302 Shirley Lane Chevy Chase, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Glenn R. Spellman, M.D.						DEGREE M.D.		22c. DATE SIGNED 9/7/86		22d. ADDRESS 4441 Hawthorne Ave NW WBC	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn R. Spellman						22f. ADDRESS 4441 Hawthorne Ave NW WBC					
23a. BURIAL, CREMATION, REMOVAL Cremation			23b. DATE 9-8-86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.			
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes ADDRESS Falls Church, Va. 22046						25a. DATE REC'D. BY REGISTRAR SEP 10 1986			25b. REGISTRAR'S SIGNATURE		

BP

00-1250



Handwritten text at the bottom of the page, appearing to be a signature or a set of initials, possibly reading "J. M. ...".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 3 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BERTHA W. MILLER				2a. DATE OF DEATH MONTH DAY YEAR 9 - 17 - 86		2b. HOUR MIN. 12: 30 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR May 8 1893		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 93 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WHCC 301 RUSSEL AVE. GAITHERSBURG MD 20878		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE West Virginia		13b. COUNTY Berkeley		13c. CITY OR TOWN Martinsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elzy Westbrock		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phoebe Loper		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 232-54-4087	
17. INFORMANT ADDRESS Mrs. Pearl Hunter Rt. 7, Box 641 Martinsburg, WV 25401		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Brain DUE TO, OR AS A CONSEQUENCE OF (b) Squamous Cell Ca, skull DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/16/86 to 9/17/86 , that (I) (we) last saw the deceased alive on 9/16/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thos G. Ward		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD		22e. ADDRESS 6116 Rehrman Rd. Bethesda 20817					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/20/86		23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley WV	
24. FUNERAL DIRECTOR Charles M. Brown		327 W. King St. PO Box 821 ADDRESS Martinsburg, WV 25401		25a. DATE REC'D. BY REGISTRAR SEP 26 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudner	

18021-00



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00-18608

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 3 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROSE MIDDLE: S LAST: MILLER			2a. DATE OF DEATH MONTH: 9 DAY: 6 YEAR: 86		2b. HOUR 10 ⁵⁵ A.M.
3. SEX FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH: 12 DAY: 25 YEAR: 08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY -----
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spg.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST: Gdalia MIDDLE: LAST: Swardlow		15. MOTHER'S MAIDEN NAME FIRST: Chaya MIDDLE: LAST: Katchen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 382-20-2670		17. INFORMANT ADDRESS: Silver Spring, Md. Gloria Wackernah; 11303 Monticello Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/5</u> 19 <u>86</u> to <u>9/6</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/5</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mark H. Sig</u>		DEGREE		22c. DATE SIGNED <u>9/6/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark H. Sig MD		22e. ADDRESS 5801 Georgia Ave Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-7-1986		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens	
23d. LOCATION CITY OR TOWN: Olney COUNTY: STATE:		23e. LOCATION CITY OR TOWN: Olney COUNTY: STATE:			
24. FUNERAL DIRECTOR NAME: Danzansky-Goldberg Chapels; 1170 Rockville Pike		24b. ADDRESS Rockville, Maryland		25a. DATE REC'D BY REGISTRAR SEP 10 1986	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/B4
(VRA 15, 4)



00-19580

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "other", the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) TERESA M. MILLETT			2a. DATE OF DEATH MONTH DAY YEAR 9-24-86			2b. HOUR 09:00 AM	
3. SEX Female		4. RACE C 1		5. DATE OF BIRTH MONTH DAY YEAR 3 27 29		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Takoma Park	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Philip delMoral				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teresa M. (Unavailable)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-60-5256		17. INFORMANT ADDRESS John J. Millett, Same as 9	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO RENAL SYNDROME DUE TO, OR AS A CONSEQUENCE OF (b) LAENNECS CIRRHOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC ETHANOLISM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from JAN , 19 82 , to 24 SEPT , 19 86 , that (I) (was) lost saw the deceased alive on 23 SEPT , 19 86 , and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death.							
22b. SIGNATURE Morrill C. Quinnam Jr				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-24-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORRILL C. QUINNAM JR				22e. ADDRESS 11120 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-25-86		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Maryland	
24. FUNERAL DIRECTOR Richard Rapp, Inc. NAME ADDRESS 1804 T Street, NW, Washington, DC 20009				25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Roberts	

MEDICAL CERTIFICATION

10/1/50
 10/1/50



HEATH K. J. - WINDY
 ANDREWS, B. J. - WINDY
 CHERRY, L. J. - WINDY

10/1/50
 10/1/50
 10/1/50

00-19451

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 4 3 5	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DAVID H MILLMAN					2a. DATE OF DEATH MONTH DAY YEAR 9-22-86			2b. HOUR 10⁴⁵ M			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-22-04		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL			
13a. STATE MARYLAND		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14510 HOMECREST RD. #20906			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH MILLMAN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE SCHOGIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 218-32-4053		17. INFORMANT DR. JULES MILLMAN ADDRESS 2322 SUGAR CONE RD. BALTO., MD 21209							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive lung disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: carcinoma of the lung											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-22-86 19 86 , to 9-23-86 19 86 , that (I) (we) last saw the deceased alive on 9-22-86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert Kramer					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-23-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER					22e. ADDRESS 10313 Georgia Ave 816 Spb. Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 25, 1986		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE				

BP

12401-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 3 6

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES DAVID MINTON			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 23 1986			2b. HOUR 11:55 A				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 16 1973		6. AGE (IN YEARS LAST BIRTHDAY) 12 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 11:55 A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE VIRGINIA			13b. COUNTY FAIRFAX		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5728 CANNON LANE 22303	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID SCOTT MINTON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SANDRA JEAN POINDEXTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 225-29-5677		17. INFORMANT ADDRESS DAVID S. MINTON, 5728 CANNON LANE, ALEXANDRIA, VA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 9 , 19 86 , to AUGUST 23 , 19 86 , that (I) (we) last saw the deceased alive on AUGUST 23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we (did) (did not) view the body after death.										
22b. SIGNATURE <i>B. G. Orr, Lt. MC, USNR</i> 22c. PHYSICIAN'S NAME (TYPE OR PRINT) B. G. ORR, LT, MC, USNR					22d. ADDRESS NAVAL HOSPITAL BETHESDA, MARYLAND 20814-5011		22e. DATE SIGNED Aug 25, 1986			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/27/86		23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA			
24. FUNERAL DIRECTOR NAME ADDRESS DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA					25a. DATE REC'D. BY REGISTRAR AUG 28 1986					
					25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>					

00-17948

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 10 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 4 3 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lieze S. Moffett						2a. DATE OF DEATH MONTH DAY YEAR Sept. 9, 1986			2b. HOUR 5:15 P_M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 29, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		8. IF UNDER 74 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4856 Chevy Chase Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Interior			
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4856 Chevy Chase Blvd. 20815			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Harrison Sasscer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lieze Fitch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-2158		17. INFORMANT ADDRESS Marjorie J. Rumrill 1005 Dennis Ave. Sil. Spg. MD 20901							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO OR AS A CONSEQUENCE OF (b) Progressive Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertensive Atherosclerotic Cardiovascular Disease DUE TO OR AS A CONSEQUENCE OF (c) 10 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH moments 4 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5652 Shields Dr. Beth., MD 20817							
22a. I certify that (I) (this hospital) attended the deceased from 11 January 83 to 9 September 86 , that (I) lost saw the deceased alive on 26 August 1986 and that in (my) opinion death occurred on the date and hour and from the causes stated above (I did not (did not) view the body after death.											
22b. SIGNATURE Dr. Michel M. Healy				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10 September 86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 9/11/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION (CITY OR TOWN) COUNTY STATE Alexandria, VA			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016						25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

0-18828

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Clayton			MIDDLE Morgan, Jr.			LAST			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR			7b. HOUR					
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 4 8 17			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 17 1986			7d. HOUR 10:48 a.m.		
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD											
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 621 Sligo Avenue (rear of)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) --			12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Wash., D.C.			13b. COUNTY			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 918 "N" St., N.W. 20001								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn.			16b. SOCIAL SECURITY NO. 249-18-5166			17. INFORMANT ADDRESS														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10: <u>Prostate cancer</u>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE <u>William M. Zane</u>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 8/18/86											
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.			ADDRESS 111 Penn St. Balto.MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal.			23b. DATE 9-9-86			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE											
24. FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS Balto., Md.			25a. DATE REC'D. BY REGISTRAR SEP 15 1986			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pond</u>											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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(VR A15 ME (5))



00-18423

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6 2 6 4 3 9	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <i>Frances Elaine Mangan</i>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9 9 1986	
3. SEX <i>female</i> 4. RACE <i>white</i> 5. DATE OF BIRTH MONTH DAY YEAR <i>July 31, 1929</i> 6. AGE (IN YEARS) LAST BIRTHDAY <i>57 YRS.</i>										7b. HOUR <i>1:00 PM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i> 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>										7c. DATE PRONOUNCED DEAD <i>9 13 1986</i> 7d. HOUR <i>3:15 PM</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>140 N. Potomac St.</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>factory</i>	
13a. STATE <i>Maryland</i> 13b. COUNTY <i>Washington</i> 13c. CITY OR TOWN <i>Hagerstown</i>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>140 N. Potomac St. 21740</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Norman E. Runyon</i>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hazel B. Wetzel</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i> (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. <i>186-24-7991</i>	
17. INFORMANT ADDRESS <i>J. William Wetzel, Hagerstown, Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest 427</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>140 N. Potomac St. Hagerstown Wash MD</i>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Allen L. D. Harrold</i> TITLE (SPECIFY) <i>M.D. Dist. Atty.</i> MEDICAL EXAMINER										DATE SIGNED <i>9/14/86</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Allen L. D. Harrold</i> ADDRESS <i>1610 Oak Hill Ave Hagerstown MD 21740</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>cremation</i>										23b. DATE <i>Sept. 14, 1986</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Smithsburg Crematory</i>										23d. LOCATION CITY OR TOWN COUNTY STATE <i>Smithsburg, Wash., Maryland</i>	
24. FUNERAL DIRECTOR <i>MINNICH FUNERAL HOME</i>										25a. DATE REC'D. BY REGISTRAR <i>SEP 18 1986</i> 25b. REGISTRAR'S SIGNATURE <i>J. William Wetzel</i>	
26. NAME <i>415 E. Wilson Blvd., Hagerstown, Maryland 21740</i>											

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8026441							
FOR 1 - STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
JESSIE		Lee		MORTON		JR		9		03	86	1635pM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
MALE		CAUCASION		10 24 24		61		MONTHS		DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
NORTH CAROLINA		U. S. A				MONTGOMERY MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
TAKOMA PARK		WASHINGTON ADVENTIST HOSP.								SELF EMPLOYED		LANGLEY CAB					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8708 BARRON ST APT #3 20912					
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME							
JESSIE LEE MORTON SR										ANNIE PRESSLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO										234-34-2049		MARY E. MORTON-8708 BARRON ST. TAK. PK. MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Massive hemoptysis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		5 mo					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DEEP VEIN THROMBOSIS WITH ANTICOAGULATION																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (the hospital) attended the deceased from August 19 86, to 3 SEPT 19 86, that (I) (we) saw the deceased alive on 25 AUGUST 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Morrell C. Quinnan Jr.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept 3, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS													
MORRILL C. QUINNAN																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		Sept. 6, 1986		Pleasant Garden Cemetery		Pleasant Garden Hail, Caroline											
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Takoma Funeral Home, J. O. Statters, 254 Carroll St NW										SEP 9 1986		J. O. Statters					

0-17547

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 4 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melvin E. MULLINIX			2a. DATE OF DEATH MONTH DAY YEAR Sept. 9, 1986		2b. HOUR 5:30 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1923		
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. CITY OR TOWN OF DEATH Damascus		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS) 26226 Purdum Rd.		14. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		16. KIND OF BUSINESS OR INDUSTRY County Schools				
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 17a. STATE Maryland 17b. COUNTY Montgomery 17c. CITY OR TOWN Damascus						
18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. STREET ADDRESS / ZIP CODE 26226 Purdum Rd. 20872				
20. FATHER'S NAME FIRST MIDDLE LAST Robert Eugene Mullinix			21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie D. Day			
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) W.W. 2		23. SOCIAL SECURITY NO. 219-12-4508		24. INFORMANT ADDRESS Shirley M. Mullinix, Item 13		
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the brain, generalized DUE TO, OR AS A CONSEQUENCE OF (b) metastases DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)						
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE		
35. I certify that (I) (this hospital) attended the deceased from 4/25 , 19 68 , to 9/9 , 19 86 , that (I) (we) lost saw the deceased alive on 9/8/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
36. SIGNATURE James P. Kerr, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				37. DATE SIGNED Sept. 9, 1986		
38. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Kerr, M.D.		39. ADDRESS 26618 Ridge Rd., Damascus, Md. 20872				
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE Sept. 11, 1986		42. NAME OF CEMETERY OR CREMATORY Bethesda Meth.		
43. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.		44. DATE REC'D. BY REGISTRAR		45. REGISTRAR'S SIGNATURE SEP 10 1986		
46. LOCATION CITY OR TOWN COUNTY STATE Browningsville, Montgomery, Md.						

MEDICAL CERTIFICATION

BP

TO HOSPITAL, CLINIC, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

101-1251-0

James P. Kerr, M.D.
2601 Ridge Rd., Damascus, Md. 20822

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HARRY W. Neal			2a. DATE OF DEATH MONTH DAY YEAR 9-2-86		2b. HOUR 11 45 P	
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4/12/07		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL				
13a. STATE Md.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14508 HOMECREST Rd. #510		20906		
14. FATHER'S NAME FIRST MIDDLE LAST FRANK NEAL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA WELLINGTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS LOIS NEAL (SAME AS #13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JAN 84 to 2 SEPT 86 , that (we) last saw the deceased alive on 2 SEPT 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not view the body after death.						
22b. SIGNATURE Walter E. Gooda MD		DEGREE MD		22c. DATE SIGNED 3 SEPT 86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOODA MD		22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE SEPT. 3, 1986		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.		
23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, PGC. MD		23e. DATE REC'D. BY REGISTRAR SEP 8 1986				
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO INC. SILVER SPRING MD		25. REGISTRAR'S SIGNATURE John. E. Jordan				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, and a coroner's inquest is required, a coroner must be notified.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jeannette N. Neel			2a. DATE OF DEATH MONTH 9 DAY 5 YEAR 86		2b. HOUR 2315 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH JAN DAY 28 YEAR 1908	6. AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS 78 DAYS 78 HOURS 78 MIN. 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE DENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md. 13b. COUNTY Montg. 13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 617 Douglas Ave./20850	
14. FATHER'S NAME FIRST Thomas MIDDLE H. LAST JOHNSON			15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE JACKSON LAST JACKSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-12-0349	17. INFORMANT ADDRESS 617 Douglas Ave Rockville, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) STATUS EPILEPTICUS DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE CVA's -					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DIABETES, CHRONIC RENAL FAILURE, CAD, CHF, ARTERIOSCLEROSIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. DATE OF OPERATION		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 24 , 19 86 , to Sept 5 , 19 86 , that (I) (we) last saw the deceased alive on Sept 5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MARCO BELLEDONNE		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCO BELLEDONNE		22e. ADDRESS 14816 PHYSICIANS LN. ROCKV.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-10-86	23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d. LOCATION CITY OR TOWN Rockville COUNTY Montg. STATE Md.
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR SEP 10 1986 25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

00-18676

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Werner			2a. DATE OF DEATH MONTH 8 DAY 31 YEAR 86			2b. HOUR 8:55 a.m.							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH SEPT. DAY 19 YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.				
10. CITY OR TOWN OF DEATH ROCKVILLE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELEPHONE			12b. KIND OF BUSINESS OR INDUSTRY TEL.CO.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALT. 13c. CITY OR TOWN BALT.						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7017-HEALTHFIELD RD. 21212				
14. FATHER'S NAME FIRST GEORGE MIDDLE OTTO LAST NEUKOMM			15. MOTHER'S MAIDEN NAME FIRST ELIZABETH MIDDLE ---- LAST STURM			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. 212-07-9359			17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD-NLH-ROCKVILLE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Heart Disease 5 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Normal pressure Hydrocephalus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Jan 29, 1979 to Aug 31, 1986 , that (I) (we) last saw the deceased alive on 8-30, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold F. M. Cann				22c. DATE SIGNED 8-31-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F. M. CANN				22e. ADDRESS 4362-26th St. N. Arlington, Va 22207	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 3/86		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE	
24. FUNERAL DIRECTOR NAME HYSONG CO., INC-1300 N ST., NW WASH., D.C. ADDRESS				25a. DATE REC'D. BY REGISTRAR SEP 19 1986 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodette			

00-18070



CHITMAN



00-17927

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Evelyn L. Noble			2a. DATE OF DEATH MONTH 9 DAY 11 YEAR 1986		2b. HOUR 1125 A
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH 2 DAY 09 YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED.		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY PR GEO	13c. CITY OR TOWN ADELPHI	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8500 LAVERNE DR 20783	
14. FATHER'S NAME FIRST George MIDDLE Royster LAST Hunt		15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE Louise LAST Whalen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-24-6903		17. INFORMANT ADDRESS Joan McCabe 8500 Laverne Dr. Adelphi 20783	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) 6 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6 months					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY 19 YEAR P.M. 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 	
22a. I certify that (1) this hospital attended the deceased from 18 Aug 86 to 11 Sept 86 , that (1) (we) last saw the deceased alive on 11 Sept 86 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE Thos A Remington PHYSICIAN'S NAME (TYPE OR PRINT)		DEGREE MD 22c. ADDRESS 7025 Greenway Ctr Drive Greenbelt Md		22d. DATE SIGNED 9/11/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/15/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION (CITY OR TOWN) Silver Spring COUNTY Montgomery STATE MD		23e. DATE REC'D. BY REGISTRAR SEP 15 1986		23f. REGISTRAR'S SIGNATURE John Davidson-Randall	
24. FUNERAL DIRECTOR Donald V. Borgwardt 4400 Powder Mill Rd. Beltsville Md 20705					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

2025 COLLECTION

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00-19368

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 6 4 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret C. Nolan			2a. DATE OF DEATH MONTH DAY YEAR September 16, 1986		2b. HOUR 7:45 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 4 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FORMER OR PRESENT) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Housewife	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8505 Springdale Rd. 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Haggarty		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Campbell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A.		17. INFORMANT ADDRESS James G. Nolan 1601 Honesty Way Bethesda, Md. 20817	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Carotid & Brachial artery aneurysms</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>9/16/86</u> to <u>9/16/86</u> , that (1) (two) (three) (four) (five) (six) (seven) (eight) (nine) (ten) (eleven) (twelve) (thirteen) (fourteen) (fifteen) (sixteen) (seventeen) (eighteen) (nineteen) (twenty) (twenty-one) (twenty-two) (twenty-three) (twenty-four) (twenty-five) (twenty-six) (twenty-seven) (twenty-eight) (twenty-nine) (thirty) (thirty-one) (thirty-two) (thirty-three) (thirty-four) (thirty-five) (thirty-six) (thirty-seven) (thirty-eight) (thirty-nine) (forty) (forty-one) (forty-two) (forty-three) (forty-four) (forty-five) (forty-six) (forty-seven) (forty-eight) (forty-nine) (fifty) (fifty-one) (fifty-two) (fifty-three) (fifty-four) (fifty-five) (fifty-six) (fifty-seven) (fifty-eight) (fifty-nine) (sixty) (sixty-one) (sixty-two) (sixty-three) (sixty-four) (sixty-five) (sixty-six) (sixty-seven) (sixty-eight) (sixty-nine) (seventy) (seventy-one) (seventy-two) (seventy-three) (seventy-four) (seventy-five) 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00-19624

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, the medical examiner will be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRACE D NORSEW			2a. DATE OF DEATH MONTH DAY YEAR 9-24-86			2b. HOUR 2353			
3. SEX Female		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 11 9 09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD CLARKSBURG		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTCOMERY MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP CLERK				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) IR S.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY MONTO. 13c. CITY OR TOWN Gaithersburg				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #7 JAMES ST. 20760			
14. FATHER'S NAME FIRST MIDDLE LAST MILTON PUTROW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMIE PURDUM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 083-360948		17. INFORMANT ADDRESS SANDRA WARD GAITHERSBURG MD 20873			

18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suspected Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suspected Cardiac Arrhythmia		minutes	
(c) Chronic Obstructive Pulmonary Disease		years	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Acute Heart Failure

19a. DATE OF OPERATION		19b. CONDITION OR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) was did not attend the deceased from 9/13 , 19 86 , to 9/24 , 19 86 , that (I) last last saw the deceased alive on 9/24 , 19 86 , and that in (my) last last opinion death occurred on the date and hour and from the causes stated above, (I) did not did not view the body after death.							
22b. SIGNATURE Stephen Newman MD				DEGREE MD		22c. DATE SIGNED 9/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Newman				22e. ADDRESS 19261 Montgomerie Village Ave, GAITHERSBURG MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-26-86		23c. NAME OF CEMETERY OR CREMATORY LEES CREMATORIAN		23d. LOCATION CITY OR TOWN STATE WASHINGTON DC.	
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24. FUNERAL DIRECTOR NAME GARTNER SANDIS		25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE John Sandis-Pudner	
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00-10024

100-20209

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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0-13-86 Per phone
FOR
1- STATE Item 2A + 18B
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DANIEL E. O'CONNELL, SR.			2a. DATE OF DEATH MONTH DAY YEAR September 14, 1986			2b. HOUR A. 8:25 M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 26, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.C. FIRE DEPT. / RETI		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY MONT.		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST DENNIS J. O'CONNELL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANORAH LEAHY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 578-09-8803		17. INFORMANT ADDRESS GENEVIEVE K. O'CONNELL - 10035 FREDERICK AVE				
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barium swallow study</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Concussion of brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(cytotoxic)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		
19a. DATE OF OPERATION 9/10/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>85</u> to <u>10/13</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/12</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22b. SIGNATURE <u>Arthur J. Wilets</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur J. Wilets				22e. ADDRESS 1111 Spring St., Silver Spring, Md.				22f. DATE SIGNED 10/6/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE OCT. 7, 1986		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE/WASHINGTON CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL MD.			
24. FUNERAL DIRECTOR NAME Takoma Funeral Home-Washington, D.C.				25a. DATE REC'D. BY REGISTRAR OCT 07 1986		25b. REGISTRAR'S SIGNATURE <u>John Anderson</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

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00-19585

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIAN Whitman O'Connor			2a. DATE OF DEATH MONTH DAY YEAR September 21, 1986			2b. HOUR 1:17A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Horse Breeder	
13a. STATE Maryland				13b. CITY OR TOWN Montgomery Rockville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William Ross Whitman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Adelaide Squire					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-3063		17. INFORMANT ADDRESS Betty Ray de Zevallos 4 Alsace Lane, Rockville, Md. 20851					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 19, 72 to August 8, 19 86 that (I) (we) last saw the deceased alive on August 8, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE John S. Saia MD						DEGREE MD		22c. DATE SIGNED 9/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Saia, M.D.						22e. ADDRESS 809 Viers Mill Road, Rockville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince Georges Md.		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes						25a. DATE REC'D. BY REGISTRAR SEP 29 1986			
300 W. Montgomery Ave. Rockville, Md. 20850						25b. REGISTRAR'S SIGNATURE Julia Davidson			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 4 and 5 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-19582

Washington, D.C. U.S.A. x

Maryland Montgomery Rockville

William Ross Whitman

No

4 Alsace Lane, Rockville, Md. 20851
Betty Ray de Nevallos
Minerva Adelaide Spurre

12201 Academy Way

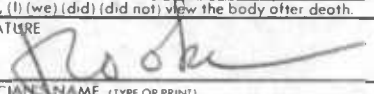
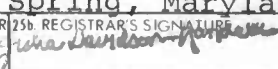
Self Employed Horse Breeder
20851

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 5 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Roy W. Olson			2a. DATE OF DEATH MONTH DAY YEAR September 2, 1986		2b. HOUR 12:30 PM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6001 Landon Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Forester	
12b. KIND OF BUSINESS OR INDUSTRY U.S. Government							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 6001 Landon Lane/20817							
14. FATHER'S NAME FIRST MIDDLE LAST Eli M. Olson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena not available			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-44-8669		17. INFORMANT ADDRESS Ann E. Olson, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 14, 1986 to Sept. 2, 1986 , that (I) (we) last saw the deceased alive on August 28, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke, M.D.				22e. ADDRESS 10400 Connecticut Avenue Kensington, Maryland 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 4, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes				25a. DATE REC'D. BY REGISTRAR SEP 5 1986		25b. REGISTRAR'S SIGNATURE 	
7557 Wisconsin Ave. Bethesda, MD 20814 PA							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

00-15110

1500

00-19366

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6

2 6 4 5 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth C. Opfar</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>09 21 86</i>		2b. HOUR <i>1015A</i>				
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec 31 1918</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1918 Rockland Avenue/20851</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Zeller</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Holzapfel</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>278 07 6987</i>		17. INFORMANT ADDRESS <i>Richard Opfar Same as # 13.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac pumping failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate onset 9/21/86</i> <i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Diabetes mellitus and possibly</i>									
19a. DATE OF OPERATION <i>9/21/86</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cardiac pumping failure</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>8601 Old Georgetown Rd Bethesda MD</i>					
22a. I certify that (I) (the hospital) attended the deceased from <i>Feb</i> 19 <i>1967</i> , to <i>9/21</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>9/21/86</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Allen J. O'Neill</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allen J. O'Neill MD</i>				22e. ADDRESS <i>8601 Old Georgetown Rd Bethesda MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept. 25, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Homes</i>				DATE REC'D. BY REGISTRAR <i>SEP 26 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

00-10000



00-17946

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Frances Enoch's Orme								September 10, 1986								10:55 AM	
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		(IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		Caucasian		June 13 1911		75		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Miss.		U.S.A.				Montgomery										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		419 Windsor Street		Homemaker		Homemaker											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
Md.		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		419 Windsor Street 20910									
14. FATHER'S NAME (TYPE OR PRINT)		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST					
Shaw				Enochs		Ruby						Hollis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		578-46-2080		Theodore S. Orme same as #13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
		Aspiratory failure		Cerebral anoxia		Chronic heart failure		2 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		ASCITES / ANEMIA															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
						9/10/86		9/10/86									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/4/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Francis J. Collins, Jr.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Francis J. Collins, Jr.		103135 Georgia Ave. Silver Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
cremation		Sept. 11, 86		Metropolitan		Alexandria				Virginia							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Francis J. Collins, Jr.		500 University Blvd., West, Silver Spring, Md.		SEP 15 1986		John J. Collins, Jr.											

[Faint, illegible handwritten text covering the majority of the page]

0-18130

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Jewell C. Owens					2a. DATE OF DEATH MONTH DAY YEAR Sept. 14, 1986				
3. SEX Female					2b. HOUR 8:39 PM				
4. RACE White					5. DATE OF BIRTH MONTH DAY YEAR April 14, 1895				
6. AGE (IN YEARS (LAST BIRTHDAY)) 91 YRS.					7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Wheaton					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home				
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MD					12b. KIND OF BUSINESS OR INDUSTRY Dept. Store				
13a. COUNTY Montgomery					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13c. CITY OR TOWN Bethesda					13d. STREET ADDRESS / ZIP CODE 6410 Landon Lane/20817				
14. FATHER'S NAME FIRST MIDDLE LAST John L. Cassidy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara --- Arenson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 495-10-9229				
17. INFORMANT ADDRESS Marjorie Pyburn, Same address as #13.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21d. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 9/14/86 to 9/14/86 that (1) (we) last saw the deceased alive on 9/14/86 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not survive the body after death.					22b. DATE SIGNED Sept. 15, 1986				
22c. SIGNATURE Myron L. Lenkin MD					22d. ADDRESS 2309 Shorefield Rd., Wheaton, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit					23b. DATE 9/15/86				
23c. NAME OF CEMETERY OR CREMATORY Lucas Hunt Cemetery					23d. LOCATION CITY OR TOWN COUNTY STATE Normandy, Missouri				
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.					25a. DATE REC'D. BY REGISTRAR				
25b. REGISTRAR'S SIGNATURE 5130 Wisconsin Ave, NW, Washington, D.C. 20016					25c. REGISTRAR'S SIGNATURE SEP 16 1986				

BP _____

London

University of London

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00-12395

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 5 5

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie B Ozabal			2a. DATE OF DEATH MONTH DAY YEAR Sept. 18, 1986		2b. HOUR 7:15P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 28, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN DC N/A Washington		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE 4000 MA Ave. NW 20016		
14. FATHER'S NAME FIRST MIDDLE LAST William P. Belt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-26-4177T		17. INFORMANT ADDRESS Audrey L. Belt Same as item # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Severe cerebrovascular insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) cerebral arterio sclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week years years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 5-2 19 86 , to 9-18 19 86 , that (I) (we) last saw the deceased alive on 9-6-86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Russell M. Tilley, Jr. M.D.		DEGREE M.D.		22c. DATE SIGNED Sept. 19, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley MD		22e. ADDRESS 4701 Mass. Ave. NW, Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/22/86	23c. NAME OF CEMETERY OR CREMATORY Arl. Nat'l. Cem.		23d. LOCATION Arlington, VA COUNTY STATE	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		ADDRESS 5130 Wisconsin Ave. NW, Washington, D.C. 20016		25a. DATE RECEIVED BY REGISTRAR SEP 24 1986	25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO 370-26-1177 Army I. 370-26-1177
 William T. Helt
 4000 M Ave. W 20018
 Home

Handwritten:
 370-26-1177 Army I. 370-26-1177
 4000 M Ave. W 20018
 Home

Handwritten:
 370-26-1177 Army I. 370-26-1177
 4000 M Ave. W 20018
 Home

00-18496

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dimitra A. Palaologos		2a. DATE OF DEATH MONTH DAY YEAR 9/15/86		2b. HOUR 7:00 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 12, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Ohio		13b. COUNTY Mahoning	13c. CITY OR TOWN Youngstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1829 Coronado Ave./44504		14. FATHER'S NAME FIRST MIDDLE LAST John --- Anagnostakis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Archondisa --- Pendaris	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 268-62-2400		17. INFORMANT ADDRESS Mrs. Andre G. Broumas, Chevy Chase, MD 20815	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Amotrophic Lateral Sclerosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Cryptogenic Retroperitoneal Hemorrhage					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/16 , 19 86 , to 9/15 , 19 86 , that (I) (we) last saw the deceased alive on 9/15 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Emmer		DEGREE MD		22c. DATE SIGNED 9/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Emmer		22e. ADDRESS 6316 Democracy Blvd., Bethesda, MD 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/19/86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, MD		24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016			
25a. DATE REC'D. BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE John D. ...			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Psychologist A. A. Kuntz

Female Date Dec. 12, 1912

U.S.A. X

Hospital Homemaker

1859 Colorado Ave. / 4-204 X Youngstown

John -- Pennsylvania --

368-62-2400 Mrs. Andre G. Brown, Navy Club, 100815



5120 Macomair Ave., Washington, D.C. 20015
Joseph G. Miller's Sons, Inc.
17. 12-10-12 Cemetery
Brentwood, Md.

0-19124

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86-26457

1. DECEASED NAME (TYPE OR PRINT) Florence V. Parkinson			2a. DATE OF DEATH MONTH DAY YEAR 9-19-86			2b. HOUR 1:42 M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 yrs. YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Utah		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE None			13b. COUNTY None		13c. CITY OR TOWN Wash., DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3133 Conn. Ave., NW 99999		
14. FATHER'S NAME FIRST MIDDLE LAST (Unavailable) Valentine				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie (unavailable) Hansen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unavailable		17. INFORMANT ADDRESS Wash., DC Kenneth W. Parkinson, Nephew, 1120 20th St., NW						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status post cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Anemia, severe DUE TO, OR AS A CONSEQUENCE OF (c) Gastrointestinal hemorrhage								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs			
								Days ?			
								Days ?			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9/18 19 86 to 9/19 19 86 , that (I) (we) last saw the deceased alive on 9/19 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did, did not view the body after death.)											
22b. SIGNATURE George S. Kenton MD			DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/20/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. KENTON					22e. ADDRESS 10620 Georgia Ave, S.S., MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Sept. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia				
24. FUNERAL DIRECTOR NAME DeVol Funeral Home, Inc. 2222 Wisc. Ave., NW., Wash., DC					25a. DATE REC'D. BY REGISTRAR SEP 26 1986		25b. REGISTRAR'S SIGNATURE John F. DeVol				

86-56127

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
SEP 26 1964
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

SEP 26 1964
[Illegible text]

00-18749

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 5 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles R. Patterson			2a. DATE OF DEATH MONTH DAY YEAR September 14, 1986			2b. HOUR 1:00 A M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 10 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9601 Pinkney Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consultant	
12b. KIND OF BUSINESS OR INDUSTRY Financial							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 9601 Pinkney Court / 20854							
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Patterson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Parkinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Ruth K. Patterson, see #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause - lost. (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) XXXXXX attended the deceased from November 60, to July 7, 1986, that (I) xx lost saw the deceased alive on July 7, 1986, and that in (my) xxx opinion death occurred on the date and hour and from the causes stated above, that (we) (did) not view the body after death.							
22b. SIGNATURE <i>John M. Wyman</i>				DEGREE MD		22c. DATE SIGNED Sept. 14, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John M. Wyman, M.D.				22e. ADDRESS 7801 Norfolk Avenue Bethesda, Maryland 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1986 Sept. 18,		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville, Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes NAME P.A. 300 W. Montgomery Av., Rockville, MD				25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



RECORDS OF FIELD

00-17899

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b. DATE KNOWN OF DEATH			MONTH			DAY			YEAR			2d. HOUR													
Irene			Virginiz			Pezcock						Sept 4 1988			17			48			M																
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD			2d. HOUR																
F			W			Sept 7 1913			72			YRS.			MONTHS			DAYS			HOURS			MIN.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																												
Washington, D.C.			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery			MD																									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																												
S. L. Spg.			Holy Cross Hosp			Teletype Supervisor			I.T.T.																												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS																									
Md			Mont.			S. L. Spg			YES			1616 Gvid			By Lane																						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																																		
John			A.			Mitchell			Lelia			M.			Lloyd																						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT																															
no			579-01-6689			Dorothy Mitchell			6004 Montana St.			New Carrollton, Md.			20784																						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY:																																					
IMMEDIATE CAUSE (a) <u>Sudden Myocardial Infarction</u>																																					
DUE TO, OR AS A CONSEQUENCE OF																																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																					
(b)																																					
DUE TO, OR AS A CONSEQUENCE OF																																					
(c)																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																					
None																																					
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?													
None																								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR												21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
												P.M. 19																									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)												21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																					
ACTUAL SIGNATURE												TITLE (SPECIFY)												DATE SIGNED													
John S. Rogers												M.D.												Sept 4 1988													
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS																									
John S. Rogers												1919 Seminary Rd., Silver Spring, Md.																									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial												Sept. 8, 88												Cedar Hill Cemetery												Suitland Prince Georges Md.	
24. FUNERAL DIRECTOR NAME												25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE													
Francis J. Collins, Jr.												20901 SEP 15 1988												John Davidson													
500 University Blvd., W., Silver Spring, Md.																																					

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to view the body.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Phillip John Peckham</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>SEPT. 19, 1986</i>			2b. HOUR <i>2:30 P.M.</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 4, 1941</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>45</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Research Physicist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>			
13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Montgomery</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <i>12417 Pretoria Drive 20904</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Willard Peckham</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret M. Dreher</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>388-40-9267</i>		17. INFORMANT ADDRESS <i>Barbara H. Peckham (Wife), Same as #13</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastrointestinal bleeding</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Septic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hodgkin's disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1-2 weeks</i> <i>15 years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Cryptococcal meningitis & septicemia</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>9/19</i> , 19 <i>86</i> , to <i>9/19</i> , 19 <i>86</i> , that (I) (we) saw the deceased alive on <i>9/19</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>G. Lennard Gold, M.D.</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/20/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. Lennard Gold</i>					22e. ADDRESS <i>8630 Fenton St., Silver Spring, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>09-23-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Mont. Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi Funeral Home, Inc.</i>					25. DATE REC'D. BY REGISTRAR <i>SEP 22 1986</i>						
11800 New Hampshire Ave, Silver Spring, Md.					25b. REGISTRAR'S SIGNATURE <i>G. Lennard Gold</i>						

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00-17319

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
JORGE			ANDRES PEREZ			9-2-86			19			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		Nov. 30, 1935		50 YRS.						9-2-86		19 2:38P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Bolivia				United States								Montgomery County MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring				10100 New Hampshire Avenue				Salesman				Insurance			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				20903	
Maryland				Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10100 New Hampshire Avenue					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS							
FIRST MIDDLE LAST				FIRST MIDDLE LAST											
Adan Perez				Masedonia Terceros											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				579-80-3355				Lourdes C. Alvarez,				9452 Jenerio Court Lorton, VA 22079			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Hanging</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				5:00 A.M. MONTH DAY YEAR P.M. 9-2-86 19				subject hanged self							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
				stair well				10100 N. Hampshire Ave. Silver Springs, Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE: <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 9-3-86			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Margarita A. Korell, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Cremation				9-5-86		Metropolitan Crematory				Alexandria, Virginia					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
NAME Richard Rapp, Inc.				SEP 8 1986				<u>John Rapp</u>							
ADDRESS 1804 T Street, NW, Washington, DC 20009															

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(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 26462
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Pearl E. Perkins		9-10-86		830 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
FEMALE	BLACK	July 14, 1923	63	YEARS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA		Mont MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Md.	Circle Manor Nursing Home		Self Employed		Re-weaver Tailor
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS / ZIP CODE		
Md. Mont		YES <input type="checkbox"/> NO <input type="checkbox"/>	2201 Nees Lane 20904		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Nathan Williams		Estelle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		579-24-2230		Mr. Joseph L. Perkins/husband/same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis, source unidentified,</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Degenerative arthritis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>13 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 7</u> 19 <u>85</u> , to <u>Sept 10</u> 19 <u>86</u> , that (we) last saw the deceased alive on <u>Sept 10</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Raymond Bradshaw, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Bradshaw, MD		22e. ADDRESS 345 University Blvd, W Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-16-86		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D BY REGISTRAR SEP 17 1986			
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th Street, N.E., D.C.		25. DATE REC'D BY REGISTRAR SEP 17 1986			

BP

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00-17921

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26463

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Milton M. Perlman			2a. DATE OF DEATH MONTH 9 DAY 12 YEAR 86		2b. HOUR 5:55 AM	
3. SEX Male		4. RACE CAUCASION		5. DATE OF BIRTH MONTH 8 DAY 08 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill of Silver Spring		12a. USUAL OCCUPATION (Ret.) Business Owner		12b. KIND OF BUSINESS OR INDUSTRY Wholesale
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST Isaac MIDDLE Perlman LAST Perlman			15. MOTHER'S MAIDEN NAME FIRST Dora MIDDLE Silberman LAST Silberman			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-46-9592		17. INFORMANT ADDRESS Silver Spring, Md. Sylvia Perlman; 15101 Interlachen Dr., #308;		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute intestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) advanced Parkinsonism						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6-13 19 86 , to 9-12 19 86 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 9-11 19 86 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE George F. Sengstack M.D.				22c. DATE SIGNED 9-12-86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE F. SENGSTACK, M.D.
22e. ADDRESS 9241 Columbia Blvd.; Silver Spring, Maryland				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/14/86		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va.
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE Gelia Gordon-Gordon

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as "Removal," the medical examiner must be notified.

00-17251

COPIES OF THE



11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, it is a violent injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 6 4

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frances C. Pesta			2a. DATE OF DEATH MONTH DAY YEAR August 30 1986			2b. HOUR MIN. 12:50 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 1 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12. CITY OR TOWN OF DEATH Silver Spring		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Center Silver Spring				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		15. KIND OF BUSINESS OR INDUSTRY D.C. Government	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 112 Quincy St. Chevy Chase, M.D. 20815.	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Hamilton Van Keuren			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Cuthbert Molten						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT ADDRESS Son in Law 6392 Scarlet Petal		Mr. David Cargo Columbia, M.D. 21045			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Pulmonary collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Uremia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Pulmonary fibrosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 28, 1986 to present , 19 86 that (I) (we) last saw the deceased alive on Aug. 28, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE D.B. Umhau MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.B. Umhau MD				22e. ADDRESS 8805 Conn. Ave., Chevy Chase MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug 31, 1986		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002			
24. FUNERAL DIRECTOR NAME J. William Lee's Son's Company				25a. DATE REC'D. BY REGISTRAR SEP 08 1986		25b. REGISTRAR'S SIGNATURE [Signature]			
26. ADDRESS 300 4th St. N.E. Washington, D.C. 20002									

00-18073

action
sift

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1. STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>June Oglesby Picke TT</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>Sept 29 '86</i>			2b. HOUR <i>7:15pm</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 1, 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Utah</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bethesda Health Care Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13c. STREET ADDRESS / ZIP CODE				
13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Montgomery</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<i>4400 Oxford Street/20896</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Milton Landis Oglesby</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella Druehl</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>238-72-8243</i>		17. INFORMANT ADDRESS <i>Suzanne P. Zbar, same as #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>None</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.									<i>None</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardiac atrophy</i>									<i>year</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>central intracerebral</i>									<i>"</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/29/86</i> to <i>9/30/86</i> , that (I) (we) last saw the deceased alive on <i>9/29/86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Thos G. Ward</i>					22c. DATE SIGNED <i>9/30/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thos G. Ward</i>					22e. ADDRESS <i>6116 Rockwood Bethesda 20817</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Sept. 30, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria, Virginia</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Robert A. Pumphrey Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814</i>					25a. DATE REC'D. BY REGISTRAR <i>OCT 03 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP

STANDARD FORM NO. 64

00-10885



00-19869

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AUDREY P. PINKARD			2a. DATE OF DEATH MONTH DAY YEAR 9 27 '86		2b. HOUR 9.40 A
3. SEX FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9 12 19		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 7 1 0 0
7a. BIRTHPLACE (COUNTRY) Washington, D. C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5010 Nantuckett Road 20740
FATHER'S NAME FIRST MIDDLE LAST William F. Burns		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Erma M. Birch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-14-7226		17. INFORMANT ADDRESS Asa G. Pinkard Husband Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) RECENT SUBENDOCARDIAL INFARCTION - DIABETES					
19a. DATE OF OPERATION 9/26/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY ARTERY DISEASE		19c. UNSTABLE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/26 , 19 86 , to 9/27 , 19 86 , that (I) (we) last saw the deceased alive on 9/27 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Hecker, M.D.		DEGREE MD.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANIR R. NEIMAT, MD.		22e. ADDRESS 10313 GEORGIA AV. SILVER SPRING, MD. 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep. 30, 1986	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Maryland
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE [Signature]	
500 University Blvd., W. Silver Spring, Md.					

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-19902

#18, 21a, f, 22a, Film G625 3/5/87 kam STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		3a. MONTH DAY YEAR		3b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
ROSS		C.		Pirrello			
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
male		white		3-24-03		83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Italy		U.S.A.		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chevy Chase		5480 Wisconsin Ave. #1501		Accountant		Dept. of Commerce	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Montgomery		Chevy Chase		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Rosario		Grace		no		123-07-6646	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF		19. DATE OF OPERATION		20. AUTOPSY?	
1920 West 17th Street Brooklyn, N.Y. 11223		Drug (Verapamil) Intoxication		19a. DATE OF OPERATION		20. AUTOPSY?	
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				19c. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
				P.M. 9/24 1986		(Acetaminophen, Temazepam, Verapamil) Subject ingested prescription medications,	
				21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home	
				21f. LOCATION		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>	
				5480 Wisconsin Ave., Chevy Chase, Mont., Md.			
				22b. DATE		22c. NAME OF CEMETERY OR CREMATORY	
				9/26/86		Metropolitan Crematory	
				22d. LOCATION		22e. COUNTY	
				Alexandria		Virginia	
				22f. DATE RECEIVED BY REGISTRAR		22g. REGISTRAR'S SIGNATURE	
				9-24-86		Bethesda	
				22h. FUNERAL DIRECTOR NAME		22i. DATE RECEIVED BY REGISTRAR	
				Francis J. Collins, Jr.		9-24-86	
				500 University Blvd. West, Silver Spring, Md.			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP 311
DHMH - 17
(VR A15 ME (5))

00-13803



00-19217

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR STATE REGISTRAR		REG. NO. 8626408									
1. DECEASED NAME (TYPE OR PRINT)		FIRST BOYAN		MIDDLE		LAST PLANINSKY		2a. DATE OF DEATH MONTH DAY YEAR 9 17 86		2b. HOUR 8¹⁰ M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 13, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bulgaria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Voice of America		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC 13a. COUNTY NA 13a. CITY OR TOWN Washington				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 4740 CT Ave. NW 20008					
14. FATHER'S NAME FIRST Nicola MIDDLE LAST Planinsky		15. MOTHER'S MAIDEN NAME FIRST Mila MIDDLE LAST Stojanova									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 141-26-8356		17. INFORMANT ADDRESS Elizabeth Planinsky Same as item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured thoracic aorta										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINS	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Abdominal aortic aneurysm resection											
19a. DATE OF OPERATION 9/17/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED aortic + iliac artery aneurysms				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/16 86 9/17 86							
22a. I certify that (I) (this hospital) attended the deceased from 9/16 86 to 9/17 86 that (I) (we) last saw the deceased alive on 9/17 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.											
22b. SIGNATURE Louis Kozloff M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/19/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS KOZLOFF M.D.				22e. ADDRESS 8218 WISCONSIN AVE BETHESDA, MD 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/23/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016						25a. DATE REC'D. BY REGISTRAR SEP 26 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

999999
DHMH 7-60M 7/84
(VRA 15, 4)

BOYD	PLANNING	
Male	June 15, 1953	63
Virginia	U.S.A.	Montgomery
eternal	Urban Hospital	Voice of America U.S. Gov't.
DC	Washington	4740 CT Ave. NW 20003
Nicola	Plannsky	Wife
NO	141-26-8756	Elizabeth Plannsky same as item 13



5130 W Ave. NW Wash., DC 20016
Lewin Jewelry Store, Inc.
Mt. Carmel Cemetery Alexandria, VA

00-18992

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ESTHER. PLOFF		9-18-86		5:15 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	4-04-17	69	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland U.S.A.	U.S.A.		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	Hebrew Home of Greater Washington	Sales Person	Clothing		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
Maryland	Montgomery	Rockville		6121 Montrose Road 20852	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT			
Benjamin Rothkind	Sophie Stein	Gaithersburg, Md. 20879			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	Barry R. Ploff (son) 11209 White Barn Ct.			
no	579 12 0771				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arrhythmia /</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast Cancer stage IV</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-10-86</u> to <u>9-18-86</u> , that (I) we lost saw the deceased alive on <u>9-18-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Loreto S. Albiol		MD		9-18-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
LORETO S. ALBIOL		6121 MONTROSE RD.			
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	Sept. 21 1986	United Hebrew Cem.	Baltimore, Maryland		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ives-Pearson Funeral Homes, Falls Church, VA		SEP 24 1986			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

NOV 10 1964

RECEIVED

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RECEIVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John C. Post			2a. DATE OF DEATH MONTH DAY YEAR 9 15 86		2b. HOUR 12 ⁵⁵ P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 5 10 1897	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY BUSINESS MGMT	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN md MONT. Chevy Chase			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME (TYPE OR PRINT) JOHN C. POST			15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) KATE GARROD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES WWI			16b. SOCIAL SECURITY NO. 579-01-4491		
17. INFORMANT THELMA B. POST (SAME AS #13 ABOVE)			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line. List (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Basilar artery thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 d 7 d -
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sick sinus syndrome, CHF, Azotemia, Atrial fib					
19a. DATE OF OPERATION 9/8/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pacemaker insertion		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/15 1986 to 9/15 1986, that (I) (we) last saw the deceased alive on 9/15 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Peter B. Sherer			DEGREE MD		22c. DATE SIGNED 9/15/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER			22e. ADDRESS 3947 Ferrara Dr. Wheaton md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-16-1986		23c. NAME OF CEMETERY OR CREMATORY BALT-WASH. CREM.	
23d. LOCATION (CITY OR TOWN) LAUREL, PR. GEO. MD.		23e. NAME OF FUNERAL DIRECTOR Takoma Funeral Home, Inc.		23f. ADDRESS 254 Carroll St. N. W. D.	
23g. DATE REC'D. BY REGISTRAR SEP 19 1986		23h. REGISTRAR'S SIGNATURE Jana Davidson-Gardner			

00-18394

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE KNOWN OF DEATH			MONTH			DAY			YEAR			2b. JUDGE								
Jung			Punga									Sept 15, 1986									A M											
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD			MONTH			DAY			YEAR			2b. JUDGE		
M			W			Oct. 2, 1916			69 YRS.									Sept. 15, 1986									A M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH															MD								
Russia			U.S.						Montgomery																							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																							
Rockville			14635 Bower Dr. Apt. 207			Office			County																							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			20853																	
Md			Mont.			Rockville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14635 Bower Dr. Apt. 207																				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																													
Herman			Punga			Helen			Rhazikozsy																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																							
No			226-38-6878			Mrs. Rita Punga - Same as #13																										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Disi</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) <u>Upper Gastrointestinal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>None</u>																																
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?																				
<u>None</u>												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) ACTUAL SIGNATURE <u>John L. Rogers</u> M.D. <u>Dep</u> MEDICAL EXAMINER DATE SIGNED <u>Sept 15 1986</u> EXAMINER'S NAME (TYPE OR PRINT) ADDRESS																																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION CITY OR TOWN COUNTY STATE														
Removal						9-15-86																										
24. FUNERAL DIRECTOR NAME ADDRESS												25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE														
Anatomy Board												Balto., Md.						SEP 17 1986 Julia Davidson-Randall														

07/84
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(VR A15 ME (5))



[Faint, illegible handwriting throughout the page, possibly a letter or document.]

0-18677

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna M Pyne			2a. DATE OF DEATH MONTH DAY YEAR 09 04 86		2b. HOUR 2:03 a.m.						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 3, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 72 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES LADY		12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.						13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST OLIVER C. BUSHAM						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE --- GAITHER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-28-8823		17. INFORMANT ADDRESS REV. DR. REICHARD- N.L.H.-ROCKVILLE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Cerebro-Vascular accident</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1972</u> to <u>Sept. 4, 1986</u> , that (I) (we) last saw the deceased alive on <u>Sept. 3, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harold F. McCann</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-4-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F. MCCANN				22e. ADDRESS 4362-26th St. N. Arlington, Va							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 8/1986		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND 21207					
24. FUNERAL DIRECTOR NAME HYSONG CO., INC-1300 N ST., NW				ADDRESS WASH., D.C.		25a. DATE REC'D. BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0-18877

NO	216-28-8823	REV.DR.REICHARD-N.L.H.-ROCKVILLE
OLIVER	C.	BUSHAM
MD.	BALTIMORE	x
ROCKVILLE	NATIONAL LUTHERAN HOME	SALES LADY UNKNOWN
MARYLAND	U.S.A.	x
FEMALE	WHITE	SEP.T. 3, 1888
		98

MONTGOMERY CO.

GALTHER

FANNIE

SEP 19 1888

0-18135

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 7 13

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MEYER RAB B		2a DATE OF DEATH MONTH DAY YEAR Sept 14, 1986		2b HOUR 1545	
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1894	
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS, LAST BIRTHDAY) 92 YRS	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker (Retired)		12b KIND OF BUSINESS OR INDUSTRY Insurance		13e STREET ADDRESS / ZIP CODE 18700 Walkers Choice Road 20879	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg	
14 FATHER'S NAME FIRST MIDDLE LAST Abraham Rabb		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Glass		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b SOCIAL SECURITY NO. 110-03-1485		17 INFORMANT Darnestown, Maryland 20878 Stephen Rabb; 15101 Falconbridge Terrace		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b, PART I OF PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9/7/86</u> <u>April 86</u> to <u>date</u> <u>1986</u> that (I) (we) last saw the deceased alive on <u>9/7/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b SIGNATURE <u>Thos G. Ward</u>		22c DATE SIGNED 9/14/86		22d PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9-16-1986		23c NAME OF CEMETERY OR CREMATORY Riverside Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland		23e DATE REC'D. BY REGISTRAR		23f REGISTRAR'S SIGNATURE SEP 16 1986	
24 FUNERAL DIRECTOR NAME Danzon's Colony Chapels; 1170 Rockville Pike					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 24 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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WIND



00-19474

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy B. Rabbitt			2a. DATE OF DEATH MONTH DAY YEAR 9 29 86			2b. HOUR 1:20AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 10, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	
12b. KIND OF BUSINESS OR INDUSTRY Nursing		13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney	
14. FATHER'S NAME FIRST MIDDLE LAST THEODORE N. BOLTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARION - HOWES		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-62-5125	
17. INFORMANT 9309 Midland Turn SHIRLEY RAGSDALE		17b. UPPER MARLBORO, MD. 20772					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. <u>Renal Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>September 26, 1986</u> to <u>September 29, 1986</u> , that (I) (we) lost saw the deceased alive on <u>September 28, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Barry Heels</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED September 29, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HEELS		22e. ADDRESS 3941 FENNIA DRIVE WILKESON, MARYLAND 20796					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCTOBER 1, 1986		23c. NAME OF CEMETERY OR CREMATORY LAYTONSVILLE		23d. LOCATION CITY OR TOWN COUNTY STATE LAYTONSVILLE MONT. MD.	
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE RECEIVED BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE	

BP _____

00-10454

0-18219

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 7 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUBY Fairfax RADCLIFF			2a. DATE OF DEATH MONTH DAY YEAR September 13, 1986			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nanjemoy, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea Woodland Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Ridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 40 Wynne Road 20680	
14. FATHER'S NAME FIRST MIDDLE LAST Peter W. Kendrick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Chase Rye					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-24-6970		17. INFORMANT ADDRESS Paul W. Clements Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 4 HS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/12/86 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this) hospital attended the deceased from 9/12/86 19 to 9/13 19 86 that (I) (we) last saw the deceased alive on 9/12/86 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard B. Delaney			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard B. Delaney MD			22e. ADDRESS 4323 HAVAN ST SC 505 MD 20946						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/86		23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtown St. Mary's			
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley Leonardtown, Md						25a. DATE REC'D. BY REGISTRAR SEP 18 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

RECEIVED

1971

10/1/71

10/1/71

10/1/71

10/1/71

10/1/71

10/1/71

GEY

00-19944

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 7 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LONNIE GORMAN RAGAN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29, 1986		2b. HOUR 3:16p M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 25, 1934		
6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman		
12b. KIND OF BUSINESS OR INDUSTRY City of Durham						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY N. CAROLINA Durham		13b. CITY OR TOWN DURHAM		13c. STREET ADDRESS / ZIP CODE 334 LEBANON CIRCLE 27712		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Ragan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Edwards				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 237-44-9797		17. INFORMANT ADDRESS ALICE A. RAGAN (WIFE) SAME AS ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) FECAL PERITONITIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 1-2 DAYS 7-WEEKS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 8, 1985 , to SEPTEMBER 29, 1986 , that <input checked="" type="checkbox"/> (we) last observed the deceased alive on SEPTEMBER 29, 1986 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated.						
22b. SIGNATURE Douglas L. Frazer		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-30-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS L. FRAZER		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20892				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Oct. 3, 1986		23c. NAME OF CEMETERY OR CREMATORY Maplewood Annex B		
23d. LOCATION CITY OR TOWN COUNTY STATE Durham, North Carolina						
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814		25a. DATE REC'D. BY REGISTRAR OCT 03 1986				
25b. REGISTRAR'S SIGNATURE						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

84821-00

3

400-18831

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Tilly		MIDDLE J.		LAST Ravillious		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH Sep		DAY 16		YEAR 1988		2b. HOUR 1:53			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH April		DAY 29		YEAR 1945		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		7c. DATE PRONOUNCED DEAD			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD													
10. CITY OR TOWN OF DEATH N.I. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.													
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4704 Arbutus Avenue 20853											
14. FATHER'S NAME FIRST Roberdau		MIDDLE		LAST Seay		15. MOTHER'S MAIDEN NAME FIRST Alice		MIDDLE		LAST Olson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 435-40-6534		17. INFORMANT 20853		ADDRESS 4704 Arbutus Ave Clarence Ravillious Rockville, MD 20853													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>None</u>																			
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>John S. Rogers</u>				TITLE (SPECIFY) M.D. Dep.				MEDICAL EXAMINER				DATE SIGNED Sep 16 1988							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Rd, Silver Spg, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 9-17-86				23c. NAME OF CEMETERY OR CREMATORY Georgetown Med School				23d. LOCATION CITY OR TOWN Washington, D.C.							
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services				ADDRESS 225 Missouri Ave, NW Washington, DC 20011				25a. DATE REC'D. BY REGISTRAR SEP 22 1988				25b. REGISTRAR'S SIGNATURE Julia Jordan-Randall							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

ADVA 1000000000
ADVA 1000000000
ADVA 1000000000



ADVA 1000000000

ADVA 1000000000

00-18286

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 7 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Genevieve M. Raynor			2a. DATE OF DEATH MONTH DAY YEAR 09 9 86			2b. HOUR 8:30p M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 23 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR SELF EMPLOYED Self Employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Wheaton									
14. FATHER'S NAME FIRST MIDDLE LAST William Elmer Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Sebelt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 000-000000-000		17. INFORMANT ADDRESS Betty Flint same as 13c					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) probable carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION 8-21-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Probable Carcinoma lung		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-21 19 86 to 9-8 19 86 that (I) (we) last saw the deceased alive on 9-8 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE V.C. D. GURMAN MD				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.C. Dr. GURMAN				22e. ADDRESS 4801 MASS AVE Wash D.C.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/12/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN STATE Suitland, Maryland	
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24. FUNERAL DIRECTOR NAME ADDRESS Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR SEP 17 1986		25b. REGISTRAR'S SIGNATURE [Signature]	
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



0-20043

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director, page 3.

DHMH: 16 30M 2/80
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 7 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter Irving Reeves, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 9-30-86		2b. HOUR 1529
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Automobile
13a. STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6640 24th Avenue 20782	
14. FATHER'S NAME FIRST MIDDLE LAST Walter I. Reeves, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Graves			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2	17. INFORMANT ADDRESS Eunice Reeves, Same as Line #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>vascular collapse -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple myeloma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1h
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/30/86</u> to <u>10/85/86</u> , that (I) (we) last saw the deceased alive on <u>9/30/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did, did not view the body after death.)					
22b. SIGNATURE <u>Martin D. Weltz</u> DEGREE				22c. DATE SIGNED 9-30-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin D. Weltz				22e. ADDRESS 7525 Greenway Ctr Oxon Green MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-3-86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia	
23d. LOCATION CITY OR TOWN COUNTY STATE				23e. DATE REC'D. BY REGISTRAR OCT 06 1986	
23f. REGISTRAR'S SIGNATURE <u>Francis Casch</u>				23g. REGISTRAR'S SIGNATURE <u>Francis Casch</u>	
23h. NAME 4739 Baltimore Ave., Hyattsville, Maryland					

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRENE REICHMANN				2a. DATE OF DEATH MONTH DAY YEAR Sept. 13, 1986			2b. HOUR 9:30p.m.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 16, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4601 No. Park Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4601 No. Park Ave., 20815	
FATHER'S NAME FIRST MIDDLE LAST Karl Schick				MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Felicia Kapauner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-84-4705		17. INFORMANT Bethesda, Maryland Raquel Dunning; 8309 Bryant Drive 20817					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR DUE TO, OR AS A CONSEQUENCE OF accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19th Street N.W. Washington, D.C.					
22a. I certify that (I) (this hospital) attended the deceased from June 1986 to September 1986 that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d/d) (did not) view the body after death.									
22b. SIGNATURE Valery A. Portnoi, M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Valery A. Portnoi, M.D.				22e. ADDRESS 1145 - 19th Street N.W., Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-1986		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE SEP 16 1986			

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[Faint, illegible text throughout the page, likely bleed-through from the reverse side. Some fragments are visible, such as "The following information was obtained from the records of the..."]

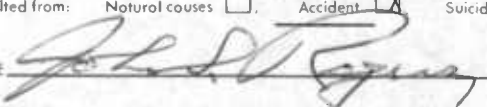
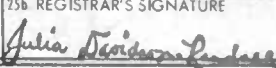
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86-26481

REG. NO.

1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Erich K. Reimer			2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> <input type="checkbox"/> MONTH DAY YEAR 9/19 1986			3. HOUR P. M. 3:58 P.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jun 7, 1908	6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9/19 1986			3. HOUR P. M. 3:58 P.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hair Stylist		12b. KIND OF BUSINESS OR INDUSTRY --		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10815 Inwood Avenue 20902
14. FATHER'S NAME FIRST MIDDLE LAST Otto Reimer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luise						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-50-9087		17. INFORMANT ADDRESS Tana M. Reimer (Wife), address same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) quadriplegia, secondary to spinal cord injury DUE TO, OR AS A CONSEQUENCE OF (c) accident. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 days 19 days									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? --					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 8/29 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Son fell off ladder onto him.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Inwood Avenue, Silver Spring, Montgomery, Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy M.D.		MEDICAL EXAMINER		DATE SIGNED 10/23/86			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09-23-86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G.Co, Maryland			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.				ADDRESS 11800 New Hampshire Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Mary			FIRST Reingold		LAST		
2a. DATE OF DEATH			MONTH 9 DAY 16 YEAR 86		2b. HOUR 4:09 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CAMPBELL NURSING FACILITY, SILVER SPRING, MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Womens Clo.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 185-05-4184	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Amiotrophic Lateral Sclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Amiotrophic Lateral Sclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from January 12, 1981 to September 16, 1986 that (I) (we) last saw the deceased alive on September 16, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Herbert S. B. Sparaf, MD		DEGREE		22c. DATE SIGNED 9/16/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT S. B. SPARAF, MD	
22e. ADDRESS 10313 GEORGINA AVE / SILVER SPRING, MD 20902		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 17, 1986		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory	
23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE		24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR SEP 18 1986		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 must be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, the medical examiner must be notified at once.

00-19575

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 6 2 6 4 8 3	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
House Lela Rhodes				9-23-86 12 41 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		White		9-5-1915	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
No. Carolina		U. S. A.		74 YRS.	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Takoma Park		Washington Adventist Hosp.		Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Beautician		Beautician			
13a. STREET ADDRESS / ZIP CODE		13b. INSIDE CITY LIMITS?		13c. CITY OR TOWN	
3333 Oak Drive 21037		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Edgewater	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Clair Broadwell		Mae Glosson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		577-09-1401		Julian K. Rhodes (Same as #13 above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Metastatic Carcinoma Liver					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
Metastatic Carcinoma Brain, Bone					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/28/86, 19 86, to 9/23/86, 19 86, that (I) (we) last saw the deceased alive on 23 Sep 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED	
		THOMAS FOGARTY M.D.		23 Sep 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
THOMAS FOGARTY		7676 N.H. Ave. Langley Park Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9-25-1986		Lakemont Cemetery	
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
TakomaFun'l Home Inc. Wash, D.C., 20012		SEP 26 1986			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGE 5 SHOULD BE KEPT WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RALPH				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9 18 1986				2b. HOUR 1:45 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept 2, 1906	6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 18 1986	7d. HOUR 1:45 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Ringler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Hemple		13e. STREET ADDRESS 11550 Stewart Lane 20904			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 715-16-0267		17. INFORMANT LeRoy Ringler		ADDRESS Box 18, Boss Rd., RD #2 Ringoes, New Jersey 08551			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt thoraco-abdominal trauma 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 1 P.M. 9-18-1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/auto collision.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 29 & Stewart La., Silver Spring, Montgomery MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Charles P. Kokes, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 9-19-86	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 09-22-86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave, Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARTHA		MIDDLE —	LAST ROGIN		2a. DATE OF DEATH MONTH 9 / DAY 11 / YEAR 86		2b. HOUR 145 ^{PM}		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 6 / DAY 27 / YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 1 YEAR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN (COUNTY)) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SOCIAL WORKER		12b. KIND OF BUSINESS OR INDUSTRY SOCIAL WORK	
13a. STATE —		13b. COUNTY —		13c. CITY OR TOWN WASHINGTON, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6230 29TH ST. NW. 26015			
14. FATHER'S NAME FIRST THOMAS		MIDDLE —		LAST ROGIN		15. MOTHER'S MAIDEN NAME FIRST ROSE		MIDDLE —		LAST ROGIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 332-30-1634		17. INFORMANT ADDRESS LAWRENCE ROGIN (BROTHER) SAME AS #13.							
16c. (IF YES, GIVE WAR OR DATES) NONE											

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>RESPIRATORY INSUFFICIENCY</u>	<u>9 MONTHS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE PULMONARY DIS</u>	<u>5 YEARS</u>
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASHD, CONGESTIVE HEART FAILURE, HYPOTHYROIDISM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
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21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		W. 1st St.	St. Louis	St. Louis	Mo.

27a. I certify that Mr. (this hospital) attended the deceased from 11/15, 1984, to 9/11, 1986, that he (we) last saw the deceased alive on 9/11, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) see the body after death.

77A. SIGNATURE Steven Lysson MD DEGREE MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ 77B. DATE SIGNED 9/4/86

77d. PHYSICIAN'S NAME (TYPE OR PRINT)	77e. ADDRESS
STEVEN LIPSON	6121 MONTROSE RD, ROCKVILL

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE SEPT. 12, 1986	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	23d. LOCATION CITY OR TOWN RIVERDALE COUNTY PG CO. STATE MARYLAND
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24. FUNERAL DIRECTOR
NAME: CHAMBERS FUNERAL HOME ADDRESS: SILVER SPRING, MD.
25a. DATE REC'D. BY REGISTRAR: SEP 15 1986 25b. REGISTRAR'S SIGNATURE: [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

MEDICAL CERTIFICATION

00-19069

BH

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST ANA E. (INITIAL ONLY) ROJAS			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 12, 1986			2b. HOUR P M 10:25 P M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR APRIL 1, 1916			6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 70 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) COLUMBIA SOUTH AMERICA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MARYLAND			13b. COUNTY MONT			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST DEMETIRIO SASTOQUE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VITALIA HOJAS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. UNKNOWN		
17. INFORMANT (SON) ALFONSO DAZA			17. ADDRESS 22421 FREDERICK ROAD CLARKSBURG, MD 20871			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>s/p aortic valve replacement</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>for acute aortic regurgitation 2° to thrombosed aortic valve</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr., 25 mins.			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____		
19a. DATE OF OPERATION September 12, 1986			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED aortic Thrombosed prosthetic valve			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from <u>November 11, 1978</u> , to <u>September 12, 1986</u> , that (I) (we) lost saw the deceased alive on <u>September 12, 1986</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE RC Robbins MD DEGREE		
22c. DATE SIGNED 9/13/86			22d. PHYSICIAN'S NAME (TYPE OR PRINT) RC ROBBINS			22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20892			22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL			23b. DATE 9/13/86			23c. NAME OF CEMETERY OR CREMATORY PUMPHREY'S FUNERAL HOME			23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D		
24. FUNERAL DIRECTOR NAME MARSHALL'S FUNERAL HOME			24. ADDRESS 4217 9TH ST. N.W., WASH, D.C.			25a. DATE REC'D BY REGISTRAR SEP 24 1986			25b. REGISTRAR'S SIGNATURE Julia Ford		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Dr. Robbins
R. C. Robbins

9/18/68

X

00-19374

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Beatrice H Robbins		2a. DATE OF DEATH MONTH DAY YEAR 9-21-86		2b. HOUR 1:13 M	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-13-00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Homemaker		13a. STREET ADDRESS / ZIP CODE 1131 University Blvd. West #618	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Hazel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Mae Edelin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 579-01-4152		17. INFORMANT Madeline H. Carter		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/31 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/31 19 86 , to 9/21 19 86 , that (I) (we) last saw the deceased alive on 9/21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David B. Kessler		DEGREE M.D.		22c. DATE SIGNED 9/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David B. Kessler, M.D.		22e. ADDRESS 10620 Georgia Ave, Silver Spring, Md. 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 24, 86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Md.		24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md. 20901			
25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

00-10374



00-17640

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26-88																																							
1. DECEASED NAME (TYPE OR PRINT) EUGENE A. ROSS						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 6 1986		2b. HOUR A																																									
3. SEX M	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR June 9, 1909	6. AGE (IN YEARS) (LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 6 1986		2d. HOUR 1300																																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co., MD																																											
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7501 DEMOCRACY BLVD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.																																									
13a. STATE MD										13b. COUNTY MONTGOMERY										13c. CITY OR TOWN BETHESDA										13d. INSIDE (CITY) LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS 7501 DEMOCRACY BLVD									
14. FATHER'S NAME FIRST MIDDLE LAST Louis N. Ross						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Parmelie Janelle																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 579-26-2485						17. INFORMANT Hazel M. Ross wife						ADDRESS same as 13																															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) HEAD INJURY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) FALL IN BATHROOM DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): PARKINSONISM																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH AM.P.M. 9 6 1986										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR AM.P.M. 9 6 1986										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL IN BATHROOM																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME										21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7501 DEMOCRACY BLVD BETHESDA MONT MD																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																																	
ACTUAL SIGNATURE Francis E Mayle										TITLE (SPECIFY) DEPT										DATE SIGNED 9-6-86																													
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS E MAYLE										ADDRESS 8200 WISCONSIN AVE BETHESDA MD										25b. REGISTRAR'S SIGNATURE 20814																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Sept. 9, 1986										23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland																			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.																				25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE 11-11-1986																			
7557 Wisconsin Ave. Bethesda, Maryland 20814																																																	

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

00-15640

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11/11/01 BY 60322 UCBAW



00-19020

DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, unless any injury, or other traumatic event, the medical examiner must be notified in writing.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Samuel R. Rubenstein</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 21 86</i>			2b. HOUR <i>1025 AM</i>					
1. SEX <i>Male</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>01 09 07</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD.</i>				
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Business Owner</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Silver Repairing</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>(20878) 842 Quince Orchard Blvd., #102</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Louis Rubenstein</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rose Browdy</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>165-01-5608</i>		
17. INFORMANT <i>Gaithersburg, Md. 20878</i>			17. INFORMANT <i>Ida Rubenstein; 842 Quince Orchard Blvd., #102</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) <i>Coronary Artery disease</i>			(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Onset 2 to 3 to 4 to 5 to 6 to 7 to 8 to 9 to 10 to 11 to 12 to 13 to 14 to 15 to 16 to 17 to 18 to 19 to 20 to 21 to 22 to 23 to 24 to 25 to 26 to 27 to 28 to 29 to 30 to 31 to 32 to 33 to 34 to 35 to 36 to 37 to 38 to 39 to 40 to 41 to 42 to 43 to 44 to 45 to 46 to 47 to 48 to 49 to 50 to 51 to 52 to 53 to 54 to 55 to 56 to 57 to 58 to 59 to 60 to 61 to 62 to 63 to 64 to 65 to 66 to 67 to 68 to 69 to 70 to 71 to 72 to 73 to 74 to 75 to 76 to 77 to 78 to 79 to 80 to 81 to 82 to 83 to 84 to 85 to 86 to 87 to 88 to 89 to 90 to 91 to 92 to 93 to 94 to 95 to 96 to 97 to 98 to 99 to 100 to 101 to 102 to 103 to 104 to 105 to 106 to 107 to 108 to 109 to 110 to 111 to 112 to 113 to 114 to 115 to 116 to 117 to 118 to 119 to 120 to 121 to 122 to 123 to 124 to 125 to 126 to 127 to 128 to 129 to 130 to 131 to 132 to 133 to 134 to 135 to 136 to 137 to 138 to 139 to 140 to 141 to 142 to 143 to 144 to 145 to 146 to 147 to 148 to 149 to 150 to 151 to 152 to 153 to 154 to 155 to 156 to 157 to 158 to 159 to 160 to 161 to 162 to 163 to 164 to 165 to 166 to 167 to 168 to 169 to 170 to 171 to 172 to 173 to 174 to 175 to 176 to 177 to 178 to 179 to 180 to 181 to 182 to 183 to 184 to 185 to 186 to 187 to 188 to 189 to 190 to 191 to 192 to 193 to 194 to 195 to 196 to 197 to 198 to 199 to 200 to 201 to 202 to 203 to 204 to 205 to 206 to 207 to 208 to 209 to 210 to 211 to 212 to 213 to 214 to 215 to 216 to 217 to 218 to 219 to 220 to 221 to 222 to 223 to 224 to 225 to 226 to 227 to 228 to 229 to 230 to 231 to 232 to 233 to 234 to 235 to 236 to 237 to 238 to 239 to 240 to 241 to 242 to 243 to 244 to 245 to 246 to 247 to 248 to 249 to 250 to 251 to 252 to 253 to 254 to 255 to 256 to 257 to 258 to 259 to 260 to 261 to 262 to 263 to 264 to 265 to 266 to 267 to 268 to 269 to 270 to 271 to 272 to 273 to 274 to 275 to 276 to 277 to 278 to 279 to 280 to 281 to 282 to 283 to 284 to 285 to 286 to 287 to 288 to 289 to 290 to 291 to 292 to 293 to 294 to 295 to 296 to 297 to 298 to 299 to 300 to 301 to 302 to 303 to 304 to 305 to 306 to 307 to 308 to 309 to 310 to 311 to 312 to 313 to 314 to 315 to 316 to 317 to 318 to 319 to 320 to 321 to 322 to 323 to 324 to 325 to 326 to 327 to 328 to 329 to 330 to 331 to 332 to 333 to 334 to 335 to 336 to 337 to 338 to 339 to 340 to 341 to 342 to 343 to 344 to 345 to 346 to 347 to 348 to 349 to 350 to 351 to 352 to 353 to 354 to 355 to 356 to 357 to 358 to 359 to 360 to 361 to 362 to 363 to 364 to 365 to 366 to 367 to 368 to 369 to 370 to 371 to 372 to 373 to 374 to 375 to 376 to 377 to 378 to 379 to 380 to 381 to 382 to 383 to 384 to 385 to 386 to 387 to 388 to 389 to 390 to 391 to 392 to 393 to 394 to 395 to 396 to 397 to 398 to 399 to 400 to 401 to 402 to 403 to 404 to 405 to 406 to 407 to 408 to 409 to 410 to 411 to 412 to 413 to 414 to 415 to 416 to 417 to 418 to 419 to 420 to 421 to 422 to 423 to 424 to 425 to 426 to 427 to 428 to 429 to 430 to 431 to 432 to 433 to 434 to 435 to 436 to 437 to 438 to 439 to 440 to 441 to 442 to 443 to 444 to 445 to 446 to 447 to 448 to 449 to 450 to 451 to 452 to 453 to 454 to 455 to 456 to 457 to 458 to 459 to 460 to 461 to 462 to 463 to 464 to 465 to 466 to 467 to 468 to 469 to 470 to 471 to 472 to 473 to 474 to 475 to 476 to 477 to 478 to 479 to 480 to 481 to 482 to 483 to 484 to 485 to 486 to 487 to 488 to 489 to 490 to 491 to 492 to 493 to 494 to 495 to 496 to 497 to 498 to 499 to 500 to 501 to 502 to 503 to 504 to 505 to 506 to 507 to 508 to 509 to 510 to 511 to 512 to 513 to 514 to 515 to 516 to 517 to 518 to 519 to 520 to 521 to 522 to 523 to 524 to 525 to 526 to 527 to 528 to 529 to 530 to 531 to 532 to 533 to 534 to 535 to 536 to 537 to 538 to 539 to 540 to 541 to 542 to 543 to 544 to 545 to 546 to 547 to 548 to 549 to 550 to 551 to 552 to 553 to 554 to 555 to 556 to 557 to 558 to 559 to 560 to 561 to 562 to 563 to 564 to 565 to 566 to 567 to 568 to 569 to 570 to 571 to 572 to 573 to 574 to 575 to 576 to 577 to 578 to 579 to 580 to 581 to 582 to 583 to 584 to 585 to 586 to 587 to 588 to 589 to 590 to 591 to 592 to 593 to 594 to 595 to 596 to 597 to 598 to 599 to 600 to 601 to 602 to 603 to 604 to 605 to 606 to 607 to 608 to 609 to 610 to 611 to 612 to 613 to 614 to 615 to 616 to 617 to 618 to 619 to 620 to 621 to 622 to 623 to 624 to 625 to 626 to 627 to 628 to 629 to 630 to 631 to 632 to 633 to 634 to 635 to 636 to 637 to 638 to 639 to 640 to 641 to 642 to 643 to 644 to 645 to 646 to 647 to 648 to 649 to 650 to 651 to 652 to 653 to 654 to 655 to 656 to 657 to 658 to 659 to 660 to 661 to 662 to 663 to 664 to 665 to 666 to 667 to 668 to 669 to 670 to 671 to 672 to 673 to 674 to 675 to 676 to 677 to 678 to 679 to 680 to 681 to 682 to 683 to 684 to 685 to 686 to 687 to 688 to 689 to 690 to 691 to 692 to 693 to 694 to 695 to 696 to 697 to 698 to 699 to 700 to 701 to 702 to 703 to 704 to 705 to 706 to 707 to 708 to 709 to 710 to 711 to 712 to 713 to 714 to 715 to 716 to 717 to 718 to 719 to 720 to 721 to 722 to 723 to 724 to 725 to 726 to 727 to 728 to 729 to 730 to 731 to 732 to 733 to 734 to 735 to 736 to 737 to 738 to 739 to 740 to 741 to 742 to 743 to 744 to 745 to 746 to 747 to 748 to 749 to 750 to 751 to 752 to 753 to 754 to 755 to 756 to 757 to 758 to 759 to 760 to 761 to 762 to 763 to 764 to 765 to 766 to 767 to 768 to 769 to 770 to 771 to 772 to 773 to 774 to 775 to 776 to 777 to 778 to 779 to 780 to 781 to 782 to 783 to 784 to 785 to 786 to 787 to 788 to 789 to 790 to 791 to 792 to 793 to 794 to 795 to 796 to 797 to 798 to 799 to 800 to 801 to 802 to 803 to 804 to 805 to 806 to 807 to 808 to 809 to 810 to 811 to 812 to 813 to 814 to 815 to 816 to 817 to 818 to 819 to 820 to 821 to 822 to 823 to 824 to 825 to 826 to 827 to 828 to 829 to 830 to 831 to 832 to 833 to 834 to 835 to 836 to 837 to 838 to 839 to 840 to 841 to 842 to 843 to 844 to 845 to 846 to 847 to 848 to 849 to 850 to 851 to 852 to 853 to 854 to 855 to 856 to 857 to 858 to 859 to 860 to 861 to 862 to 863 to 864 to 865 to 866 to 867 to 868 to 869 to 870 to 871 to 872 to 873 to 874 to 875 to 876 to 877 to 878 to 879 to 880 to 881 to 882 to 883 to 884 to 885 to 886 to 887 to 888 to 889 to 890 to 891 to 892 to 893 to 894 to 895 to 896 to 897 to 898 to 899 to 900 to 901 to 902 to 903 to 904 to 905 to 906 to 907 to 908 to 909 to 910 to 911 to 912 to 913 to 914 to 915 to 916 to 917 to 918 to 919 to 920 to 921 to 922 to 923 to 924 to 925 to 926 to 927 to 928 to 929 to 930 to 931 to 932 to 933 to 934 to 935 to 936 to 937 to 938 to 939 to 940 to 941 to 942 to 943 to 944 to 945 to 946 to 947 to 948 to 949 to 950 to 951 to 952 to 953 to 954 to 955 to 956 to 957 to 958 to 959 to 960 to 961 to 962 to 963 to 964 to 965 to 966 to 967 to 968 to 969 to 970 to 971 to 972 to 973 to 974 to 975 to 976 to 977 to 978 to 979 to 980 to 981 to 982 to 983 to 984 to 985 to 986 to 987 to 988 to 989 to 990 to 991 to 992 to 993 to 994 to 995 to 996 to 997 to 998 to 999 to 1000</i>											

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <i>(the hospital)</i> attended the deceased from <i>9/19 1986</i> , to <i>9/21 1986</i> , that (I) <i>(was)</i> lost saw the deceased alive on <i>9/19 1986</i> , and that in (my) <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(did)</i> <i>(did not)</i> view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/21/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gregor</i>		22e. ADDRESS <i>12105 Quince Orchard Rd G.B.</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/23/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Judean Memorial Garden</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>City: Montgomery, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i>				25. DATE RECEIVED BY REGISTRAR <i>SEP 23 1986</i>			
1170 Rockville Pike; Rockville, Md. 20852				25b. REGISTRAR'S SIGNATURE			

100-10050

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00-17918

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Florence Sage			2a. DATE OF DEATH MONTH DAY YEAR 9-9-1986			7b. HOUR 4:25 AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-2-1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 yrs.		8. IF UNDER 1 YEAR MONTHS DAYS YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) London England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.						
10. CITY OR TOWN OF DEATH Bethesda.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Gros Venor Health Care Center.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME				
13a. STATE MD.			13b. COUNTY P.G.C.		13c. CITY OR TOWN BRENTWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4406 38th ST. 20722			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT MARGARET JOHNSON		ADDRESS 635 CONCERTO LA. SILVER SPRING, Md. 20901					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive lung disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Atherosclerotic heart disease, multiple medical problems												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NO 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A						
22a. I certify that (I) (this hospital) attended the deceased from 7-10 , 19 86 , to 9-9 , 19 86 , that (I) (we) last saw the deceased alive on 9-3 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
27b. SIGNATURE Amer						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 9-9-86		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMAN R. TULI						27e. ADDRESS 16220 FREDERICK RD. GAITHERSBURG, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-12-1986		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, ARL. CO., VA.				
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. 5801 CLEVELAND AVE, RIVERDALE						25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-17813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please replace the certificate in this envelope. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 6 2 6 4 9 1

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Ethel Salladay			2a. DATE OF DEATH MONTH DAY YEAR September 2, 1986			2b. HOUR 10:40 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 25 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) Nebraska.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, National Institutes of Health				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fed. Govt, Retired.	
13a. STATE Maryland		13b. COUNTY MONT		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST KUEHN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOT AVAILABLE		13e. STREET ADDRESS / ZIP CODE 2000 Franwall Ave 20902			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 506-05-2488		17. INFORMANT ADDRESS Mr. Cam Salladay, husband, same			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) FUNGAL AND BACTERIAL SEPTICEMIA, PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c) BREAST CARCINOMA

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <u>May 8</u> , 19 <u>84</u> , to <u>Sept. 2</u> , 19 <u>86</u> , that (X) (we) last saw the deceased alive on <u>Sept. 2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Henry C. Stover				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 09-03-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY C. STOVERSON MD				22e. ADDRESS Clinical Center, National Institutes of Health, Bethesda, Md. 20892			

23a. BURIAL, CREMATION, REMOVAL Burial.		23b. DATE Sept. 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Md. Vets. Cheltenham Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Takoma Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR SEP 9 1986			
25b. REGISTRAR'S SIGNATURE							

BP

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0-18495

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 9 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BULA E. SANDERS			2a. DATE OF DEATH MONTH 9 DAY 17 YEAR 86			2b. HOUR 5³⁰ A.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Nov. DAY 7 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL BETHESDA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher			12b. KIND OF BUSINESS OR INDUSTRY Teaching		
13a. STATE ---		13b. COUNTY ---		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3900 Watson Pl., NW/20016			
14. FATHER'S NAME FIRST Christopher MIDDLE C. LAST Beverly				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE E. LAST Carter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 451-30-3465		17. INFORMANT ADDRESS Hazel M. Murdock, Same address as #13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 weeks 10+ years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Cerebral vascular accident with left hemiplegia - 1942											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Sept , 19 80 , to 9/17 , 19 86 , that (I) (we) lost saw the deceased alive on 8/30 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard M. Huffman M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/17/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. HUFFMAN, M.D.						22e. ADDRESS 3301 NEW MEX. AVE. WASH., D.C. 20016					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b. DATE 9/17/86		23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Humble, TX					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

00-18774

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Everett L. Santos			2a. DATE OF DEATH MONTH DAY YEAR September 19, 1986			2b. HOUR 11:45P M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 26, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Cuba		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8540 Horseshoe Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Import/Export	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Paul Santos			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josefa Enguriez			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWI			
16b. SOCIAL SECURITY NO. 081-12-4370			17. INFORMANT ADDRESS Mr. Everett J. Santos, Son, Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostatic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 5 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1986</u> , to <u>Sept 19, 1986</u> , that (I) (we) lost saw the deceased alive on <u>Sept 16, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>David Jacobs M.D.</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/20/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID JACOBS, M.D.			22e. ADDRESS 6314 TONE DR, Bethesda 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Woodlawn North Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Miami Florida		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey, Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, MD.					25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE <u>Frederick Anderson</u>		

BP

00-18781

00-18781

00-19065

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anne H. SARKIN			2a. DATE OF DEATH MONTH 9 DAY 22 YEAR 86			2b. HOUR 4 MIN 15					
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH 7 DAY 3 YEAR 11		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION, (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp. Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY Dept. Stores			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery				13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14510 Homocrest Road 20906			
14. FATHER'S NAME FIRST Isaac MIDDLE Bernard LAST Cohen				15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Rebecca LAST Fisher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 168-03-3033		17. INFORMANT Arline J. Wilcox ADDRESS 3030 Aquarius Avenue, Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure										2 years	
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) metastatic breast cancer involving bone producing thrombocytopenia											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/1 , 19 84 , to 9/22 , 19 86 , that (I) (we) last saw the deceased alive on 9/21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Bruce A. Silver, MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE A. SILVER				22e. ADDRESS 106 Irving St. N.W. #421, Wash DC 20010							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/23/1987		23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon		23d. LOCATION CITY OR TOWN Hyattsville, COUNTY P. G. STATE Md.			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR					
25b. REGISTRAR'S SIGNATURE SEP 24 1987											

5
00-18080

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, immediately call the State Dept. of Health and Mental Hygiene for further instructions.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 9 5

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmer W. Schaake		2a. DATE OF DEATH MONTH DAY YEAR 8 20 86 2b. HOUR 5:10 am	
3. SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1905	6 AGE (IN YEARS LAST BIRTHDAY) 80 years IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Engineer 12b. KIND OF BUSINESS OR INDUSTRY unknown
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton
14. FATHER'S NAME FIRST MIDDLE LAST William Schaake		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kipp	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 212-01-5017	17 INFORMANT ADDRESS Dr. Richard Reichard Rockville, Md. 9701 Veirs Dr.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Clinical Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Polymicrobial Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>24 April</u> 19 <u>86</u> to <u>19 April</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>19 April</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.			
22b. SIGNATURE <u>Thomas E. Dooley, MD</u>	22c. DATE SIGNED <u>20 April 86</u>	22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS E. DOOLEY, MD	
22e. ADDRESS 9701 VEIRS ROAD ROCKVILLE, MARYLAND 20850		22f. REGISTERAR'S SIGNATURE <u>Julia D. [Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 25, 1986	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24 FUNERAL DIRECTOR NAME The Hysong Company 1300 N St. Wash. D.C.		25. DATE REC'D. BY REGISTRAR SEP 05 1986	

03081-00



00-19671

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 6 4 9 6

1. DECEASED NAME (TYPE OR PRINT) HAROLD T. SCHALL			2a. DATE OF DEATH MONTH DAY YEAR 9-26-86		2b. HOUR 5:20 P.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 20 1997		6. AGE (IN YEARS LAST BIRTHDAY) 89 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPT.		12a. USUAL OCCUPATION (TYPE OF WORK FOR AM. WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
13a. STATE M.D.							
13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 107 CROYDON CT. 20910	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM SCHALL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 579-05-5186		17. INFORMANT ADDRESS MR. CRAIG JOHNSON 5901 33rd AVE, HYATTSVILLE Md. 20782			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy onset</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia + Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Left lower lobe pneumonia, Decubiti ulcers</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unable to</u> <u>precise</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: all above, also atherosclerosis

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>September 25</u> , 19 <u>86</u> , to <u>September 26</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>September 26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>JA Queros MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>September 26, 1986</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JA Queros MD		22e. ADDRESS 4343 MONTGOMERY AV Bethesda MD 20814					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-30-1986		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE, MONTG. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.				ADDRESS SILVER SPRING, Md.		25a. DATE REC'D. BY REGISTRAR OCT 01 1986	
						25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

RECEIVED
JAN 10 1960
FBI - NEW YORK

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

00-19222

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 0 2 6 4 9 1

1. DECEASED NAME (TYPE OR PRINT) Lillian Schwartz			2a. DATE OF DEATH MONTH DAY YEAR September 18, 1986		2b. HOUR 7:44A M		
4. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 10, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE New York		13b. CITY OR TOWN Kings		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 800 Cortelyou Road (11218)	
14. FATHER'S NAME FIRST MIDDLE LAST Morris Bond				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tillie Glicksberg			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 057052-3495		17. INFORMANT Sidney Schwartz; 4628 W. Frankfort Drive; Rockville, Md. 20853			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD & Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Left leg embolus SIP emblectomy							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/18-2AM, 1986 to 9/18, 7AM, 1986 , that (I) (we) last saw the deceased alive on 9/18, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Neil Julie		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Julie, M. D.				22e. ADDRESS 2901 Olney-Sandy Spring Road Olney, Maryland 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/21/86		23c. NAME OF CEMETERY OR CREMATORY King Solomon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clifton Park, New Jersey	
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16-60M 7/B4
(VRA 15, 4)

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00-19476

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 9 8

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME FIRST MIDDLE LAST ESTHER WEBB SCOTT			SEPTEMBER 27, 1986			12:30AM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR JULY 16, 1895		
6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH OLNEY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		
12b. KIND OF BUSINESS OR INDUSTRY Education			13a. STREET ADDRESS 17025 Norwood Road 20860					
13b. CITY OR TOWN Sandy Spring			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL I. SCOTT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ESTHER WEBB					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 228-44-4862			17. INFORMANT Mark P. Lehelle Norbeck, Md. 20906		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Generalized convulsions + bacterial sepsis. Hypogammaglobulinemia, Pneumonia</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 14, 1986</u> to <u>27 Sept 1986</u> , that (I) was lost saw the deceased alive on <u>26 Sept 1986</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) will did not view the body after death.								
22b. SIGNATURE <u>Donald E. Dillon</u> MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>27 Sept 86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E. DILLON, M. D.			22e. ADDRESS OLNEY, MD. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT. 29, 1986			23c. NAME OF CEMETERY OR CREMATORY FRIENDS CEMETERY		
23d. LOCATION CITY OR TOWN COUNTY STATE SANDY SPRING MONT. MD.			24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879			25a. DATE OF REGISTRATION SEP 29 1986		
25b. REGISTRAR'S SIGNATURE								

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00-18572

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEANNETTE C. SEIDLITZ			2a. DATE OF DEATH MONTH 9 - DAY 13 - YEAR 86			2b. HOUR 410 A.M.											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May DAY 29 YEAR 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7. IF UNDER 24 HRS HOURS 0 MIN. 0							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10. CITY OR TOWN OF DEATH Takoma park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY B'Nai Brith							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1400 Fenwick Lane Apt. 615 20910									
14. FATHER'S NAME FIRST Abraham MIDDLE L. LAST Carliph			15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE Caminesky LAST Caminesky			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 093-12-4197A		17. INFORMANT Stanley A. Seidlitz		17. ADDRESS 4748 Virginia Street, Fairfax, Virginia 22032	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cardiogenic shock, granulomatous interstitial lung disease																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 9/16 , 19 83 , to 9/15 , 19 86 , that (I) (we) lost saw the deceased alive on 9/12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE Thomas S. Locke, III				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/13/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas S. Locke, III				22e. ADDRESS 8580 Second Ave Silver Spring, Md. 20910													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/15/1986		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden				23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia							
24. FUNERAL DIRECTOR DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.								25a. DATE REC'D. BY REGISTRAR SEP 17 1986		25b. REGISTRAR'S SIGNATURE Julia Tindler-Pudner							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 must be completed. The medical examiner must be notified of death.

BP

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60-789-1

00-15253



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JULIUS SELIGMAN			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 21, 1986			2b. HOUR P 5:15_M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR December 21, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5015 BATTERY LANE. BETH. MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Retail Clothing	
13a. STATE MD.		13b. COUNTY MONTG.		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5015 BATTERY LANE 20814	
14. FATHER'S NAME FIRST MIDDLE LAST Leopold Seligman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jacobina Wolf					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-22-8384		17. INFORMANT ADDRESS Kensington, Md. 20895 Ellen Zweig; Daughter; 11224 Woodson Ave.;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B: PART 1 OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/26/86 to 9/21/86 , that (I) viewed the deceased alive on 9/21/86 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE Myron L. Lenkin					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN, M.D.					22e. ADDRESS 2309 SHOREFIELD RD. SSPG, MD. 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/24/86		23c. NAME OF CEMETERY OR CREMATORY WASH. HEBREW CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM CHP INC. ADDRESS 1170 ROCKVILLE PK. ROCKVILLE MD.					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE SEP 23 1986		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, together with the death certificate, for use as the burial-transit permit. Then please remove carbon papers. Page 1 shall be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 86 26502									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR AM PM	
Max			Shaffer			9-3-86		8:40 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		CAUC.		3 10 96		90		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore MD.		USA				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Carriage Hill Nursing Home				Liquor Salesman		Disc International	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Silver Spring				1220 Blair Mill Road, #1402 (20910)	
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)						
LEON			SHAFFER			UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO		578-07-2353		#906; Silver Spring, Md. 20902 Lenora Jewler; Daughter; 1131 Univ. Blvd., West					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Infection</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of prostate</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
<u>Arteriosclerotic heart disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 27</u> 19 <u>86</u> to <u>present</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept. 2</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22a. SIGNATURE									
22b. PHYSICIAN'S NAME (TYPE OR PRINT)									
22c. ADDRESS									
22d. DATE SIGNED									
22e. DEGREE									
22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22g. SIGNATURE									
22h. ADDRESS									
22i. DATE SIGNED									
22j. DEGREE									
22k. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22l. SIGNATURE									
22m. ADDRESS									
22n. DATE SIGNED									
22o. DEGREE									
22p. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22q. SIGNATURE									
22r. ADDRESS									
22s. DATE SIGNED									
22t. DEGREE									
22u. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22v. SIGNATURE									
22w. ADDRESS									
22x. DATE SIGNED									
22y. DEGREE									
22z. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22aa. SIGNATURE									
22ab. ADDRESS									
22ac. DATE SIGNED									
22ad. DEGREE									
22ae. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22af. SIGNATURE									
22ag. ADDRESS									
22ah. DATE SIGNED									
22ai. DEGREE									
22aj. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22ak. SIGNATURE									
22al. ADDRESS									
22am. DATE SIGNED									
22an. DEGREE									
22ao. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22ap. SIGNATURE									
22aq. ADDRESS									
22ar. DATE SIGNED									
22as. DEGREE									
22at. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22au. SIGNATURE									
22av. ADDRESS									
22aw. DATE SIGNED									
22ax. DEGREE									
22ay. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22az. SIGNATURE									
22ba. ADDRESS									
22bb. DATE SIGNED									
22bc. DEGREE									
22bd. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22be. SIGNATURE									
22bf. ADDRESS									
22bg. DATE SIGNED									
22bh. DEGREE									
22bi. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22bj. SIGNATURE									
22bk. ADDRESS									
22bl. DATE SIGNED									
22bm. DEGREE									
22bn. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22bo. SIGNATURE									
22bp. ADDRESS									
22bq. DATE SIGNED									
22br. DEGREE									
22bs. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22bt. SIGNATURE									
22bu. ADDRESS									
22bv. DATE SIGNED									
22bw. DEGREE									
22bx. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22by. SIGNATURE									
22bz. ADDRESS									
22ca. DATE SIGNED									
22cb. DEGREE									
22cc. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22cd. SIGNATURE									
22ce. ADDRESS									
22cf. DATE SIGNED									
22cg. DEGREE									
22ch. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22ci. SIGNATURE									
22cj. ADDRESS									
22ck. DATE SIGNED									
22cl. DEGREE									
22cm. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22cn. SIGNATURE									
22co. ADDRESS									
22cp. DATE SIGNED									
22cq. DEGREE									
22cr. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22cs. SIGNATURE									
22ct. ADDRESS									
22cu. DATE SIGNED									
22cv. DEGREE									
22cw. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22cx. SIGNATURE									
22cy. ADDRESS									
22cz. DATE SIGNED									
22da. DEGREE									
22db. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
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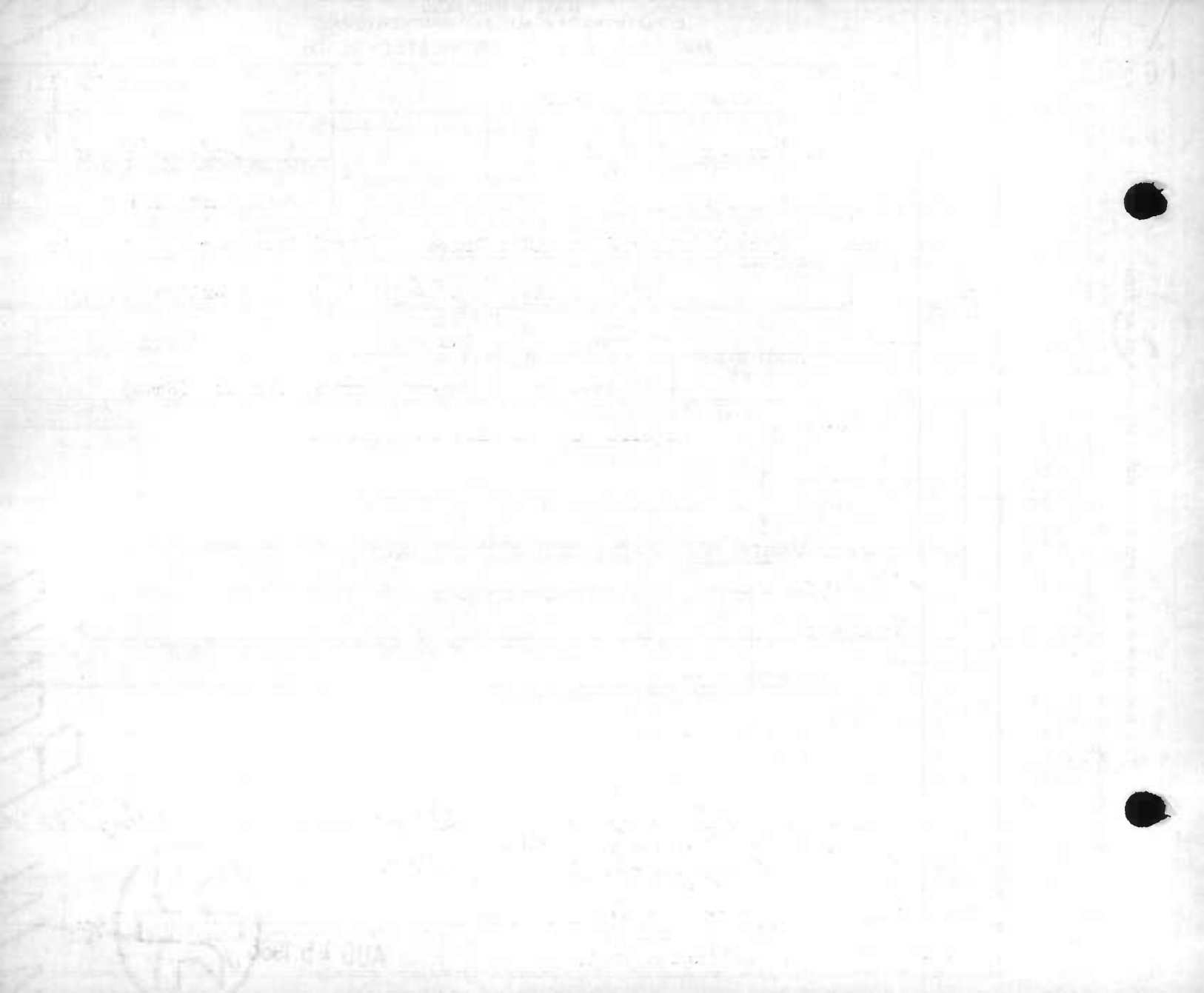
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SEP 29 1980

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 0 5

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lawrence Shub			2a. DATE OF DEATH MONTH DAY YEAR 9/15/86		2b. HOUR 4:45 A					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1018 Hollywood Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY US Govt.		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1018 Hollywood Ave., 20904	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Shub			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Radin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT ADDRESS Flora M. Shub-wife- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cachexia of cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 9-15 , 19 86 , to 9/15 , 19 86 , that (I) (we) last saw the deceased alive on 9-15 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Bruce A. Silver			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/15/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE A. SILVER			22e. ADDRESS 106 Irving St, N.W. #44, Wash DC 20010							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-16-1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION Adelphi Pr. Georges Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home			11800 N.H. Ave. Silver Spring, Md.			25a. DATE REC'D BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 19, state any injury, or other traumatic event, the medical examiner must be notified at once.

0-11305

FOX COLLOM-11305



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST LULA A. SIEFER			MONTH DAY YEAR SEPTEMBER 14, 1986			12:30 A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	Caucasian	MONTH DAY YEAR Feb. 2 1898	88 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Kansas	U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring	2300 Eccleston Street			Housewife			Housewife	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Md.			Montgomery			Silver Spring		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST Lilbrun Funkhouser			FIRST MIDDLE LAST Julia Schneider			2116 Dexter Ave. #102 20902		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
			509-10-0812			Mary Louise Knobbe Silver Spring, Md. 20902		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>								24 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>								YRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/86</u> to <u>9/14/86</u> that (I) (we) last saw the deceased alive on <u>8/1/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Alan I. Kerpmaier, MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			<u>9/1/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
ALAN I. KERPMAYER, MD			10313 Georgia Ave. S.E. M/F 2022					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			Sept. 18, 86		Franklin Cemetery		Franklin Venango Penn.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md.			SEP 18 1986					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SEPTEMBER 14, 1958

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00-17550

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 6 5 0 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Edward Simcock				2a. DATE OF DEATH MONTH DAY YEAR 09-07-86		2b. HOUR 10 30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 23 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) QUEBEC CANADA		7b. CITIZEN OF WHAT COUNTRY? PERM. RESIDENT USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BAKERY		12b. KIND OF BUSINESS OR INDUSTRY PART OWNER	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY CO		13c. CITY OR TOWN TAKOMA PARK	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 8109 ROANOKE AVE 20912			
14. FATHER'S NAME FIRST MIDDLE LAST John Simcock				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRTIE DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-48-1594		17. INFORMANT ADDRESS RUBY M. D. SIMCOCK, 8109 ROANOKE AVE T.P.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Gastrointestinal Bleed DUE TO, OR AS A CONSEQUENCE OF (b) Gastric Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) Lymphoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 1 week
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/5/86 9/7/86		21g. DATE SIGNED 9/8/86	
22a. I certify that (1) (this hospital) attended the deceased from [] to [] and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above. (1) (yes) (did) (did not) view the body after death.				22b. SIGNATURE Thomas A. Bensinger		22c. ADDRESS 7525 Greenway Ctr Drive Greenbelt	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Zion Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY Brentwood MD 20870	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home				25a. DATE REC'D. BY REGISTRAR SEP 10 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

(2014)

NOV

8

5

MEMORANDUM

TO: THE CHIEF OF POLICE

FROM: THE CHIEF OF POLICE

SUBJECT: [Illegible]

DATE

TIME

PLACE

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

00-18075

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		MONTH DAY YEAR	
EVELYN SIMMONS		8-26-86 19		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR	8. IF UNDER 24 HRS.
Female	Hispanic	Aug 6, 1959	27 YRS.	MONTHS DAYS	HOURS MIN.
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED	
Belize		Belize		NEVER MARRIED	
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Bethesda		Suburban Hospital		Domestic	
15. BALTIMORE CITY OR COUNTY OF DEATH		16. KIND OF BUSINESS OR INDUSTRY		17. PRIVATE IND.	
Montgomery County		Private Ind.			
18. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19. INSIDE CITY LIMITS?		20. STREET ADDRESS	
18a. STATE 18b. COUNTY 18c. CITY OR TOWN		YES NO		21. 8306 14th Avenue #302	
Maryland P. Georges Hyattsville					
22. FATHER'S NAME		23. MOTHER'S MAIDEN NAME		24. ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		25. Hyattsville, Md.	
Passi Simmons		Maria Simmons		26. Angel Vidal, Uncle, 8306 14th Ave., #302	
27. WAS DECEASED EVER IN U.S. ARMED FORCES?		28. SOCIAL SECURITY NO.		29. INFORMANT	
YES NO		Not Stated		30. Angel Vidal, Uncle, 8306 14th Ave., #302	
31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		32. IMMEDIATE CAUSE (a)		33. DUE TO, OR AS A CONSEQUENCE OF	
8147		Head and neck injuries			
34. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		35. (b)		36. DUE TO, OR AS A CONSEQUENCE OF	
37. (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
38. DATE OF OPERATION		39. CONDITION FOR WHICH OPERATION WAS PERFORMED?		40. AUTOPSY?	
19a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		19b. TIME OF INJURY		19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
6:02PM 8-26-86		pedestrian struck by a vehicle			
20. INJURY OCCURRED WHILE AT WORK		21. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		22. LOCATION	
NOT WHILE AT WORK		street		River Rd. & Carderock Springs Dr. Mont. Co., Md.	
23. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner					
24. ACTUAL SIGNATURE DATE SIGNED					
Margarita A. Korell, M.D. 111 Penn Street 8-27-86					
25. EXAMINER'S NAME (TYPE OR PRINT) ADDRESS					
Margarita A. Korell, M.D. 111 Penn Street					
26. BURIAL, CREMATION, REMOVAL (SPECIFY)		27. DATE		28. NAME OF CEMETERY OR CREMATORY	
BURIAL		3 Sep 86		Mount Olivet Cemetery	
29. FUNERAL DIRECTOR		30. DATE REC'D. BY REGISTRAR		31. REGISTRAR'S SIGNATURE	
W. ERNEST JARVIS CO., INC.		1432 You St., NW		SEP 08 1986	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

00-18072



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 signs any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26509

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MONG			MIDDLE CHI			LAST SIN			2a. DATE OF DEATH MONTH DAY YEAR 9-7-86				2b. HOUR 2010 M	
3. SEX FEMALE			4. RACE Korean			5. DATE OF BIRTH MONTH DAY YEAR 7 17 15			6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea			7b. CITIZEN OF WHAT COUNTRY? Korea			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSURE FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital						12a. USUAL OCCUPATION (TYPE OR WORK, AND IF OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. STATE Maryland			13b. COUNTY Prince Georges			13c. CITY OR TOWN Beltsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11304 Evanstrail Road			
14. FATHER'S NAME FIRST MIDDLE LAST Sang Ok Sin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bo Young Kim											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE LAST 4 DIGITS) N/A			17. INFORMANT ADDRESS You Bok Yang-son- (same as 13e)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bangrene Small Bowel DUE TO, OR AS A CONSEQUENCE OF (b) Mesenteric Artery Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION 9/7/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diagnostic Mini Lap.						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9-7-86 , to 9-7-86 , that (I) (we) lost saw the deceased alive on 9-7-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Robert A. Smith													22c. DATE SIGNED 9-7-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Smith			22e. ADDRESS 7610 Carroll Ave Takoma Park Md 20912											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-10-1986			23c. NAME OF CEMETERY OR CREMATORY Norbeck Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Olney Montgomery Md.					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			ADDRESS 11800 N.H. Ave. Silver Spring, Md.			25a. DATE REC'D BY REGISTRAR SEP 9 1986			25b. REGISTRAR'S SIGNATURE Jana L. Gordon					

BP

00-17488

0-19194

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 1 0

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET B. SKINNER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 23, 1986		2b. HOUR 8:20 P.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 7, 1902		
6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		
13a. STATE DC		13b. COUNTY WASHINGTON		13c. STREET ADDRESS / ZIP CODE 6200 OREGON AVE., NW 20015		
14. FATHER'S NAME FIRST MIDDLE LAST HUGH H. BRECKENRIDGE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROXANNA G. HOLME				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-34-2776		17. INFORMANT ADDRESS 1301 DOWNS DR. SILVER SPRING, MD 20904		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 23 SEP 86 to 23 SEP 86 , that (I) (we) last saw the deceased alive on 23 SEP 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Edward P. Fox</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>24 Sept-86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. FOX, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/25/86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia						
24. FUNERAL DIRECTOR Hines/Rinaldi		25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

CHIEF OF POLICE



00-18950

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND-21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Stanley A Slocum</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>9 15 86</u>		2b. HOUR <u>5:10 AM</u>		
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>4 30 19</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTG.</u> MD.	
10. CITY OR TOWN OF DEATH <u>Md.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Engineer</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>							
13a. STATE <u>D. C.</u>		13b. CITY OR TOWN <u>Washington</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <u>2011 Monroe Street, N.E.</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Sidney Slocum</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Grutrud Stroud</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>107-14-7579</u>		17. INFORMANT ADDRESS <u>Mrs. Dorothea W. Slocum/wife/same as 13e</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Renal Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/22/86</u> , 19 <u>86</u> , to <u>9/15</u> , 19 <u>86</u> , that (I) (last) saw the deceased alive on <u>9/14</u> , 19 <u>86</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frank N. Gravino</u>				22c. ADDRESS <u>10313 Georgia Ave, Silver Spring, MD</u>		22d. DATE SIGNED <u>9/15/86</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>9-19-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood, Md.</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>John T. Rhines Co., 3015 12th St. N.E., D.C. 20017</u>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>SEP 23 1986 Julia Davidson-Henderson</u>			

DHMH - 16 60M 7/B4
(VRA 15, 4)

10/10/70

CA



10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

00-19872

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 1 2

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bradley B. Smith, Jr.			2a. DATE OF DEATH MONTH 9 DAY 26 YEAR 86			2b. HOUR 5 28 AM					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH Jan. DAY 27 YEAR 1933		6. AGE (IN YEARS LAST BIRTHDAY) 53		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Broker			12b. KIND OF BUSINESS OR INDUSTRY Stock Exchange		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1809 Sherwood Road 20902			
14. FATHER'S NAME FIRST Bradley MIDDLE Burch LAST Smith Sr.				15. MOTHER'S MAIDEN NAME FIRST Hope MIDDLE Ritter LAST Ritter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 256-34-4252		17. INFORMANT mother ADDRESS Hope Ritter Smith same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF RIGHT LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from AUGUST 1986 to SEPTEMBER 26 1986 , that (I) (we) last saw the deceased alive on SEPTEMBER 25 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE James G. Brown				DEGREE				22c. DATE SIGNED 9/28/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN, MD				22e. ADDRESS 14800 PHYSICIANS LANE, #232 ROCKVILLE, MD 20850							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE SEPT. 29, 86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. West, Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified.

BP _____

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00-19364

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 1 3

1. FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy H. Smith</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9/21/1986</i>		2b. HOUR <i>21:50</i> M
3. SEX <i>Female</i>	4. RACE <i>Can.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12/12/13</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Toledo, Ohio</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery.</i> MD.		
10. CITY OR TOWN OF DEATH <i>Takoma Park.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Beautician</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beautician</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Izabelski</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Magdelene Malecki</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>290-16-5206</i>	17. INFORMANT ADDRESS <i>4360 292nd Street, Carol Jean Nehrig Toledo, Ohio 43611</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 Minutes</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>					<i>Years</i>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Sepsis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/16</i> 19 <i>86</i> to <i>9/21</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>9/21</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>22 Sept 86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael Leibovich MD</i>		22e. ADDRESS <i>11120 Kithurst Rd 20907</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>9-24-1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balt-Wash. Crematory Laurel, P.G. Md.</i>	
24. FUNERAL DIRECTOR <i>[Signature]</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 26 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

27

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11/13

RECEIVED

00-20253

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Cleared by Cr. John S. Rogers M.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 1 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL LEROY SMITH			2a. DATE OF DEATH MONTH DAY YEAR 9 30 86			2b. HOUR 11 22 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 9, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12117 Bayswater Rd. 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Jessie L. Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rice			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT ADDRESS Irene B. Smith same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION WITH VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: :							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/30, 1986, to 9/30, 1986, that (we) lost saw the deceased alive on 9/30, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Byrl D. Johnson		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BYRL D. JOHNSON		22e. ADDRESS 911 N. RUSSELL AVE. GAITHERSBURG MD. 20879					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/3/86		23c. NAME OF CEMETERY OR CREMATORY Resthaven Memorial Gardens		23d. LOCATION CITY OR TOWN Frederick, Maryland	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR OCT 06 1986			
				25b. REGISTRAR'S SIGNATURE John S. Rogers			

BP

00-50323

32
0-18440STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

66 26515

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARA SMITH			2a. DATE OF DEATH MONTH DAY YEAR 9-12-86		2b. HOUR 11:05 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 1-1-1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN U.S. CITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS (ZIP CODE) 14203 CASTAWAY DRIVE 20853					
14. FATHER'S NAME FIRST MIDDLE LOUIS SMITH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE ANNA (UNASCERTAINABLE)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 061-34-8291		17. INFORMANT EDWARD SMITH, 14203 CASTAWAY DRIVE, ROCKVILLE, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia Severe.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Alzheimers Dementia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 10 years.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>7-10-86</u> to <u>9-12-86</u> , that (1) (we) last saw the deceased alive on <u>9-12-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE LORETO S. ALBIOL		DEGREE MD		22c. DATE SIGNED 9-12-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORETO S. ALBIOL		22e. ADDRESS 6121 MONTROUSE RD.			
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 9/15/1986	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN FUNERAL SERVICES		23d. LOCATION ALEXANDRIA, VIRGINIA
24. FUNERAL DIRECTOR'S NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.			25a. DATE REC'D. BY REGISTRAR SEP 17 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

01481-0

20% COTTON

00-17749

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VM-3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) VICKIE JEAN SMITH			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 5 1986			2b. HOUR 21 41 M		
3. SEX Female	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 12 7 1946	6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 5 1986	7d. HOUR 21 41 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.		
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Private Nursing,
13a. STATE MD			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN GATHERSBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 8218 SHADY SPRING DR 20760		
14. FATHER'S NAME FIRST MIDDLE LAST Harry Barrrs Vassie			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Elizabeth Thornton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 220 59 0056		17. INFORMANT ADDRESS Nolan S. Smith, see #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC C. ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) C. VERROSE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 2-3 HRS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 7-8 P.M. 9 5 1986		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7-8 P.M. 9 5 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) TOOK PILLS				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8218 SHADY SPR. DR GATH, MD MONTGOMERY				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Francis C. Mayle		TITLE (SPECIFY) DEPT MEDICAL EXAMINER		DATE SIGNED 9/6/86		20814		
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE		ADDRESS 8200 WILSON AVE WASH BETHESDA MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/transit		23b. DATE Sept. 11, 1986		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lakeland Florida		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home,				25a. DATE REC'D BY REGISTRAR SEP 11 1986		25b. REGISTRAR SIGNATURE [Signature]		
P.A. 300 W. Montgomery Av., Rockville, Md								

10-18563

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Maude Snyder			2a. DATE OF DEATH MONTH DAY YEAR 9/10/1986			2b. HOUR 2.45 A.M.				
1. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 30 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 413 Waterford Rd. S. Spring, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. STATE PA			13b. COUNTY Cambria		13c. CITY OR TOWN Johnstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Wallace Hechler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Younkinn			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 413-26-6745	
17. INFORMANT ADDRESS 15146 PA			Paul Snyder 1377 Hillsdale Dr. Monroeville							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding diathesis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widespread metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable lymphoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2-4 mo</u> <u>4-6 mo</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-18</u> , 19 <u>86</u> , to <u>9-10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-9</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Richard P. Delaney</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.			22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-12-1986		23c. NAME OF CEMETERY OR CREMATORY Rockwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockwood Somerset PA			
24. FUNERAL DIRECTOR NAME John Henderson Co.			25a. DATE REC'D. BY REGISTRAR SEP 17 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Henderson-Randall</u>					

0-18283

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For information of the Council, the following
is submitted for the Council's consideration
and action.
The Council is requested to consider the
following and to take such action as it may
deem proper.
The Council is requested to consider the
following and to take such action as it may
deem proper.
The Council is requested to consider the
following and to take such action as it may
deem proper.

00-18718

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH										21. HOUR	
1. DECEASED NAME (TYPE OR PRINT) JENNIE MARYLAND SONNEBORN										20. DATE KNOWN OF DEATH 9 16 19 86										21. HOUR 9⁰⁰ A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8 22 01		6. AGE (IN YEARS) 85		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		20. DATE PRONOUNCED DEAD 9 17 19 86		21. HOUR 3⁰⁰ P							
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				71. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 199 Rollins Ave. #307				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home									
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 199 Rollins Ave. #307 20852											
14. FATHER'S NAME Leonard						15. MOTHER'S MAIDEN NAME Pearl						15. MOTHER'S MAIDEN NAME Powell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212 40 4380		17. INFORMANT Rockville, Maryland 20852															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Cardiac arrest																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Coronary arterio Sclerosis																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																					
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER Bethesda Md.				DATE SIGNED 9-17-86									
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 9/19/86				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland									
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852										25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE John Davidson									

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

751-01

00-19365

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Barbara L. Spies						Sept. 22, 1986		9:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		May 22, 1920		66		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Kensington		4317 Glenridge St.				Editor		C I A	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD		Montgomery		Kensington				4317 Glenridge St./20895	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Edwin --- Spies			Lousie --- Byrnes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				
Yes			WW II		131-18-9288 Celeste Boland, Same address as #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>									<u>Weeks</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the head of the tongue</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>83</u> , to <u>9-22</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE			DEGREE					22c. DATE SIGNED	
<u>Russell M. Tilley, Jr.</u>			M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					9/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Russell M. Tilley			4701 Mass. Ave, NW, Wash., D.C. 20016						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation			9/24/86		Mt. Comfort Crematory		Alexandria, VA		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016					SEP 26 1986		<u>Julia Anderson</u>		

BP

COAST GUARD

COMMUNICATIONS SECTION
U.S. COAST GUARD

RECEIVED
JAN 11 1966
U.S. COAST GUARD

U.S. COAST GUARD
JAN 11 1966

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00-17333

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Robert	MIDDLE S.	LAST Stahl	2a. DATE KNOWN OF DEATH ESTI- MATED			8 MONTH 12 DAY 1988	2b. HOUR 7:35 PM	
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1932	6. AGE (IN YEARS LAST BIRTHDAY) 54	RS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD	12 1988	7d. HOUR 7:35 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Senior Manager		12b. KIND OF BUSINESS OR INDUSTRY Marketing			
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2005 Stratton Drive/20854			
14. FATHER'S NAME FIRST MIDDLE LAST Barton E. Stahl			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Sheridan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea 577-40-2446		17. INFORMANT ADDRESS Clotilda F. Stahl (wife) Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John S. Rogers</u>				TITLE (SPECIFY) M.D. <u>Dep.</u>				DATE SIGNED Sep 23 1988			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers M.D.			ADDRESS 1919 Seminary Road Silver Spring, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 6, 1988		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA				25a. DATE REC'D. BY REGISTRAR SEP 8 1988						25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	
300 West Montgomery Avenue Rockville, Maryland											

00-1533

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00-18464

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8026521

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERMA GARRETT STEELE			2a. DATE OF DEATH MONTH DAY YEAR Sept. 13, 1986			2b. HOUR 7:40A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL BETHESDA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE ---		13b. COUNTY ---		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5420 Connecticut Ave, NW/20015	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Jasper Garrett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola -- Mc Guinness					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-86-8521		17. INFORMANT ADDRESS 112 Pine Street V/Adm. George P. Steele, Phila., PA 19106			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) --- DUE TO, OR AS A CONSEQUENCE OF (c) ---								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that N (this hospital) attended the deceased from 4-19-1984 to 9-13-1986 , that N (we) last saw the deceased alive on 8-25-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, N (we) (did) (did not) view the body after death.									
22b. SIGNATURE John E. Kelly						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Kelly				22e. ADDRESS 9715 Medical Center Dr. NW 20810					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/18/86		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE RECEIVED BY REGISTRAR SEP 19 1986					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

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Dr. J. D. Robinson, Jr., Director, U.S. Forest Service

00-19723

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA PATTON STEGER			2a. DATE OF DEATH MONTH DAY YEAR September 29, 1986		2b. HOUR P 3:30 M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 15, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL- BETHESDA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. STATE Florida			13b. COUNTY Polk		13c. CITY OR TOWN Winter Haven		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 928 15th Street, NE 33881		
14. FATHER'S NAME FIRST MIDDLE LAST Raymond S. Patton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Mitchell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-01-5071	
17. INFORMANT Helen Patton Wright			ADDRESS 5317 Blackstone Road			17. INFORMANT Bethesda, MD 20816					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) several years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING: OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) [this hospital] attended the deceased from Sept 20 19 86 to present 19 86 , that (I) [we] last saw the deceased alive on Sept 28 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. I. Passes		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/29/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. I. PASSES MD				22e. ADDRESS 3701 Mass Ave Washington DC 20016							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-30-86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc.				ADDRESS 1804 T Street, NW, Washington, DC 20009		25a. DATE REC'D. BY REGISTRAR OCT 02 1986		25b. REGISTRAR'S SIGNATURE John A. [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

2020 CATION FIBER

WITNESS: [Signature]

(Seal)

0-18395

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ashley Dawn Stephenson			2a. DATE OF DEATH MONTH DAY YEAR Aug. 18, 86		2b. HOUR 12:48p_M
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1986		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 3	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16220 Frederick Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None
13a. STATE Maryland		13b. COUNTY Prince Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Not Given		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beverly Jean Stephenson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mother 15013 Nighthawk La., Bowie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a twin gestation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug, 18, 1986 , to Aug. 18, 1986 , that (I) (we) last saw the deceased alive on Aug. 18, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Janet Schaffel</i> MD				22c. DATE SIGNED 9-10-86	
22d. PHYSICIAN'S NAME (TYPE COMPLETE) Janet Schaffel, MD				22e. ADDRESS 16220 Frederick Rd. #419 Gaithersburg, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		24. FUNERAL DIRECTOR NAME ADDRESS Metropolitan Funeral Service 5515 Vine Street, Alexandria, Va.			
25a. DATE RECD. BY REGISTRAR SEP 17 1986				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

IMPORT ANT: If item 21 is marked as item 18 states any injury, or other traumatic event, the medical examiner must be notified prior to funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-staples. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-staples. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

0-18382

VOID

CERTIFICATE # 06-26524

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00-19383

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR			
Dwight Robert Stoffer, Jr.								9/ 13/19 86								11:28 P M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
Male	Caucasian	3 12 46		40 YRS.						9/ 13/19 86									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Indiana		U.S.A.						Montgomery County, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE				12b. KIND OF BUSINESS OR Medical C							
Silver Spring		14725 Good Hope Rd.						Special Systems				Walter Reed							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		14725 Good Hope Rd. 20904											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST				FIRST MIDDLE LAST															
Dwight R. Stoffer, Sr.				Dolly Leming															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INVENTORY ADDRESS															
yes		1965-69 & 76-86		217-46-7880		Barbara Stoffer 10159 Sutherland Road, Silver Spring, Md. 20901													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Smoke and Soot Inhalation																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				11:20 PM 9/13/1986				subject in house fire											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
				home				14725 Good Hope Rd., Silver Springs, Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
John E. Smialek, M.D.				111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				Sept. 18, 86				Arlington National				Arlington Arlington Va.							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Francis J. Coblins, Jr.				SEP 25 1986															
500 University Blvd. West, Silver Spring, Md. 20901																			

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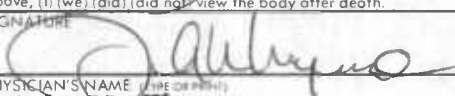
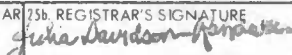
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked other than 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 86 26526			
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Anna Stone				2a. DATE OF DEATH MONTH Sept DAY 19 YEAR 86		2b. HOUR 1:10 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 21 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville Montgomery		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN INSTITUTION, GIVE STREET ADDRESS) 11407 Farmland Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST Leon MIDDLE LAST Rhenn				15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE LAST Bub			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 139-54-2291		17. INFORMANT ADDRESS Betty L. Crotty (daughter) same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							(b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF							(c) 2 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 31 Oct , 19 78 , to 19 Sept , 19 86 , that (we) lost 12 Aug , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE 				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 19 Sept 86	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) John M. Wyman				27e. ADDRESS 7801 Norfolk Avenue Bethesda, Md. 20814			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 9/22/86		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY Cheltenham, Maryland	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike, Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE 	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 5 2 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST BETTY		MIDDLE K.		LAST STRATTON		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		12-24-15		70 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PA		USA				Montgomery County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Adventist Hospital						? RETIRED		Housewife	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE					
Md. PA. Prin. E. Lothian		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 19 Patuxent Mobile Est., Lothian, MD 20711							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. ADDRESS							
Joseph -- Kirkwood		Edith -- Earl		same as 13c							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
no		188-248689		Calvin Stratton							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CARDIAC ARREST											
DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR FAILURE											
DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE CORONARY ARTERY DISEASE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEVERE AORTIC DISEASE - POST AORTIC VALVE REPLACEMENT & BYPASS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
9/17/86		SEVERE AORTIC DISEASE & CORONARY ARTERY DISEASE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/16, 1986, to 9/17, 1986, that (I) (we) last saw the deceased alive on 9/17, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
A. Reany MD		MD									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
SAMIR NGIMAT, MD		10313 GEORGIA AV. SILVER SPRING, MD, 20902									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		9/20/86		Lakemont Cemetery		Davidsonville A.A. MD.					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Rausch Funeral Home, PO Box 45, Owings, MD 20736				SEP 23 1986							



1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
STEPHEN		ARON		SULLIVAN				SEPTEMBER 25, 1986								6:15 PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		(IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		WHITE		AUG 30, 1961		25		YRS		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MONTGOMERY COUNTY								MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		Army & AF								Exchange Svc.			
BETHESDA		THE CLINICAL CENTER, NIH		Mechanic															
USUAL RESIDENCE (IF NURSING HOME OR OTHER INST.)		13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE											
MARYLAND		MONT		GAITHERSBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		408 GIRARD ST. # 102 20879											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST		FIRST MIDDLE LAST																	
Unknown		Marjorie Lou Sullivan																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (WIFE)		ADDRESS													
no		541-80-9267		BARBARA R. SULLIVAN		SAME AS PT													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) RESPIRATORY ARREST																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b) METASTASIS TO THE BRAIN, CHEST, PELVIS																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) SKIN TUMOR																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION															
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME STREET FACTORY OFFICE FARM ETC.)		STREET CITY OR TOWN COUNTY STATE															
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 19 19 84 to SEPTEMBER 25 19 86, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on SEPTEMBER 25 19 86, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																			
22b. SIGNATURE																DEGREE		22c. DATE SIGNED	
J. Lecciones MD																ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		9-26-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																22e. ADDRESS			
JULIUS A. LECCIONES, M.D.																NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20894			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION													
Removal		9-27-86		Lehman Funeral Home		City or Town County State		Swoyerville Pa.											
24. FUNERAL DIRECTOR																25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Marshall's Funeral Home ADDRESS 4217 9th St NW: Washington, D.C.																SEP 30 1986		John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP.

60-10777



100-10777-140

RECEIVED

00-19905

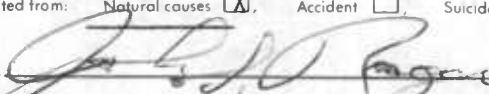

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

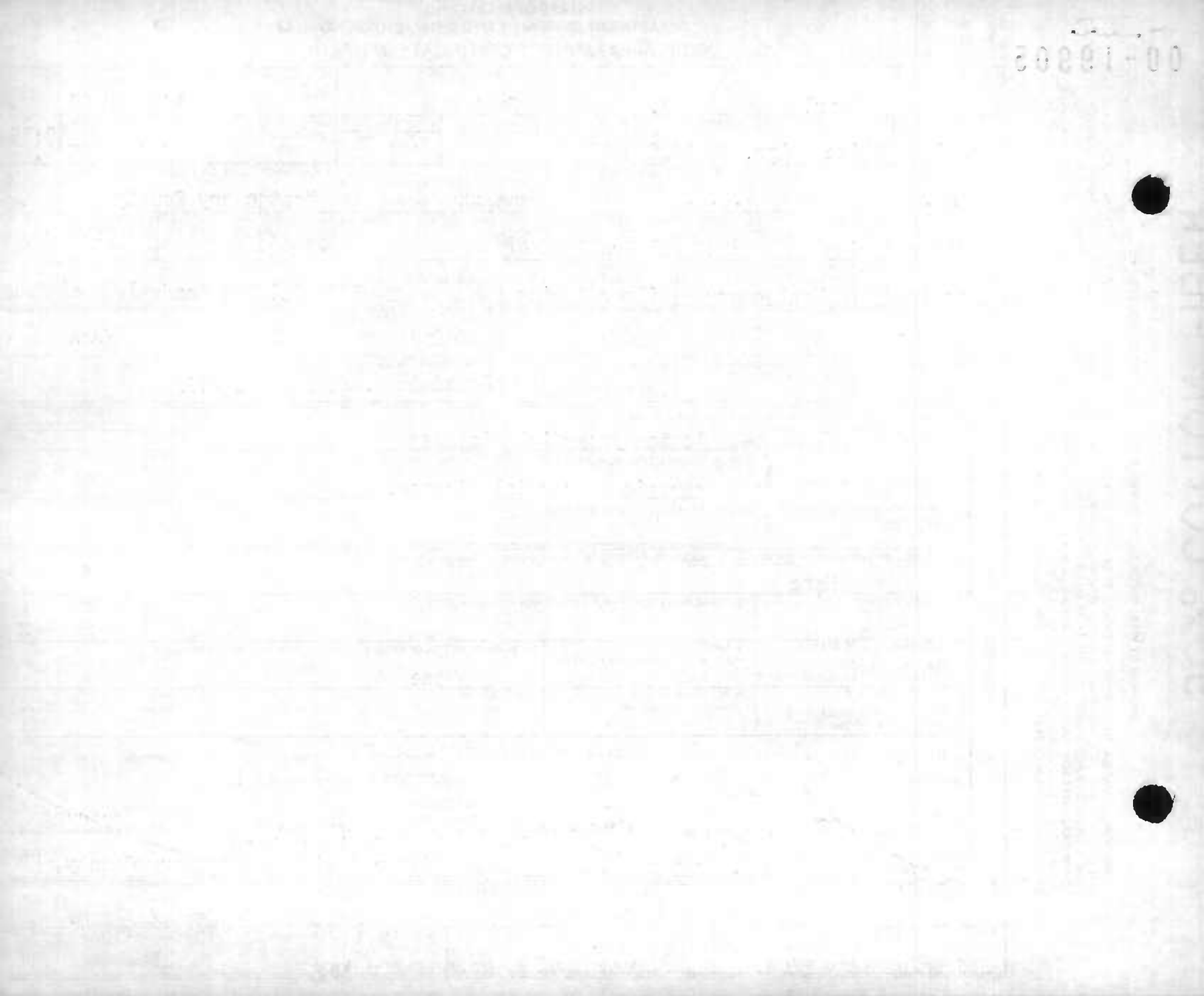
1. DECEASED NAME (TYPE OR PRINT)			FIRST Pearl			MIDDLE V.			LAST Swab			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9/26 19 86			2b. HOUR A. M. 8:30 A.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 9, 1903		6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9/26 19 86		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife					
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3842 Bel Pre Road #1				12c. KIND OF BUSINESS OR INDUSTRY Housewife									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3842 Bel Pre Road #1									
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Wentz						15. MOTHER'S MAIDEN NAME FIRST MIDDLE Daisy M. Miller											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 201-01-5504				17. INFORMANT Granddaughter ADDRESS Patricia A. Dix same as #13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) chronic myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 1919 Seminary Road				DATE SIGNED 9/26/86					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS Silver Spring, Montgomery County, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept. 29, 1986				23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Johnstown Cambria Penn.					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR OCT 03 1986				25b. REGISTRAR'S SIGNATURE 									
500 University Blvd. West, Silver Spring, Md.																	

07/84
25M

BP _____

DHMH - 17
(VR A15 ME (5))

00-19802



00-19941

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic cause, the head of examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 86 / 26530							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 9-29-86				2b. HOUR 8:30 AM			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM E SWINK				6. AGE (IN YEARS LAST BIRTHDAY) 60				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11-7-25		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			
7a. BIRTHPLACE (COUNTY) Washington DC.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION Millhand Ameters		12b. KIND OF BUSINESS OR INDUSTRY Capt. Smith			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital		12c. STREET ADDRESS / ZIP CODE 6400 WESTMORELAND AVE 20912		13. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 6400 WESTMORELAND AVE			
13a. STATE MARYLAND		13b. COUNTY TAKOMA PARK		13c. CITY OR TOWN MONTGOMERY		14. FATHER'S NAME FIRST MIDDLE LAST VICTOR BONNEY SWINK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA SKELTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W.W. II 57-30-0058		17. INFORMANT ANNA E. SWINK		17. ADDRESS (SAME AS #13 ABOVE)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE, CARDIAC ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) VIRAL PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE PULMONARY FIBROSIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-22-1986 to 9/29/1986, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 9/29/86	
22b. SIGNATURE Tony P. Kannarkat				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/29/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tony P. KANNARKAT				22e. ADDRESS 8201 16th ST SILVER SPRING MD 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Oct 2 1986 Burial.				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery.			
23d. LOCATION CITY OR TOWN COUNTY STATE P. G.				23e. DATE REC'D. BY REGISTRAR OCT 03 1986				23f. REGISTRAR'S SIGNATURE			
Takoma Funeral Home, Inc. 254 Carroll St. N. W. D. C.										Md.	

BP

00-18745

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Samuel Tash				2a. DATE OF DEATH MONTH DAY YEAR Sept. 18, 1986		2b. HOUR 1:10p.m.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11430 Strand Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaners	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Tash				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yetta Dick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Kenneth Tash ADDRESS 1216 N. Belgrade Rd., Silver Spring, Md. 20902			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c) BLADDER CANCER PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) xxx attended the deceased from 11/5 , 19 85 , to 9/18 , 19 86 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 8/28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) xxx did (did xxx) view the body after death.							
22b. SIGNATURE Stanley A. Schwartz DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/18/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley A. Schwartz, M.D.				22e. ADDRESS Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 21, 1986		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Park		23d. LOCATION CITY OR TOWN STATE Falls Church, Va.	
24. FUNERAL DIRECTOR NAME Ives-Pearson F.H. ADDRESS Falls Church, VA				25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

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00-18747

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
MARY ROSALIE TAYLOR						SEPTEMBER 11 1986			11:05 P			
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		CAUCASIAN		DECEMBER 31 1915		70			MONTHS DAYS		HOURS MIN.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
VIRGINIA		UNITED STATES				MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NAVAL HOSPITAL				Columnist (R)			Potomac News			
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
VIRGINIA		PRINCE WM.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX		18353 SHARON ROAD 22172						
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
THOMAS RILEY				JULIA DONOVAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
NO		226-10-6543		MARY ELIZABETH SCHREINER		6722 ANNANDALE ROAD, ANNANDALE, VA 22003						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 15 1986 to SEPTEMBER 11 1986, that (I) (we) last saw the deceased alive on SEPTEMBER 11 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE DEGREE						22c. DATE SIGNED						
Edward P. Fox MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						12 Sept. 86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
E. P. FOX, 1t, MC, USNR						NAVAL HOSPITAL BETHESDA, MD 20814-5011						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			Sept. 15, 1986		Quantico National			Triangle, Virginia				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Cunningham-Mountcastle Funeral Home 13318 Occoquan Road Woodbridge, VA 22191						SEP 22 1986						

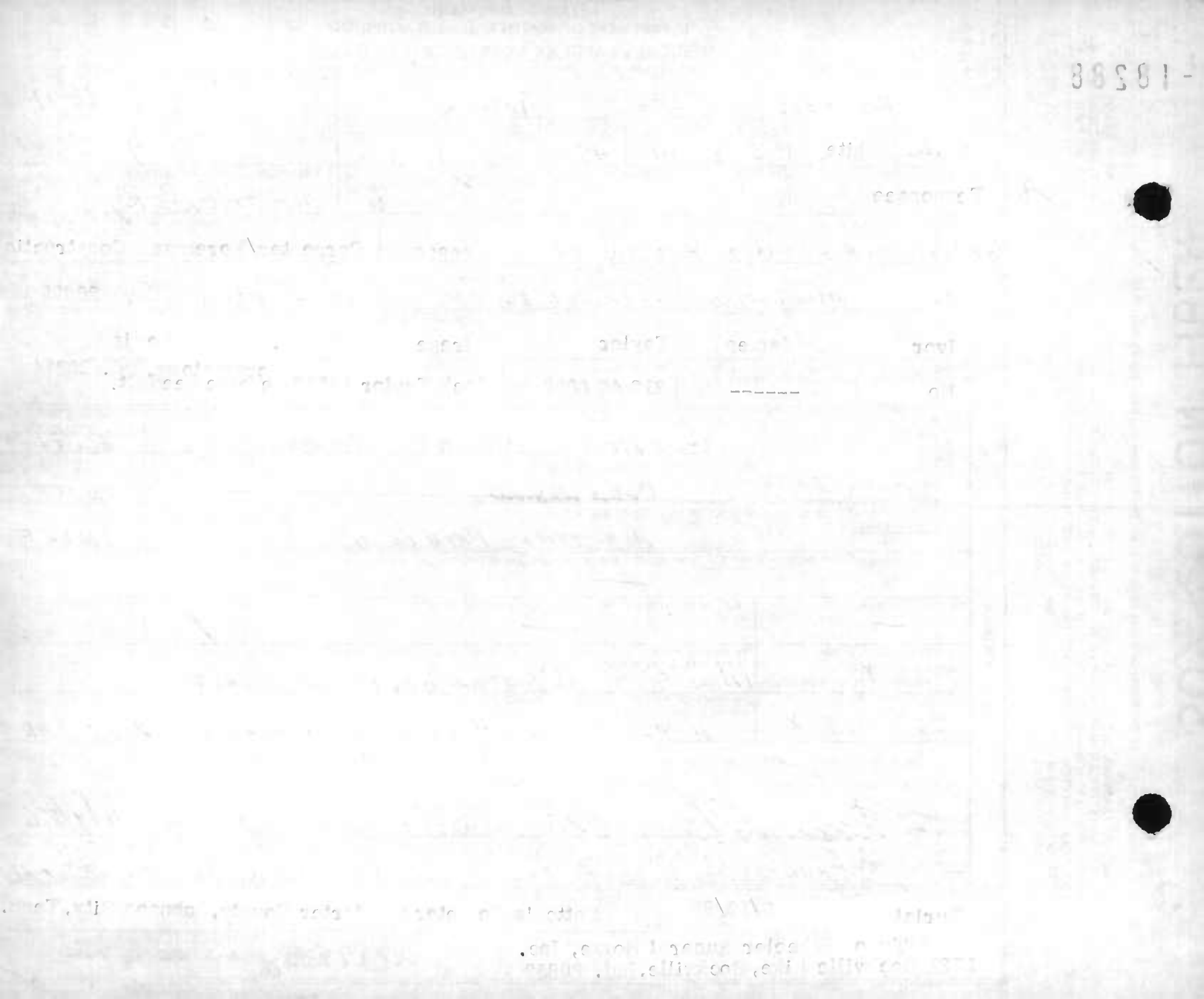
MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1- FOR STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST WENDELL LEE TAYLOR								2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 9 1986		2b. HOUR 1750	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 2 41		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 45		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 45 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 9 1986		7d. HOUR 1912	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH GAITHERSBURG				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 107 HUTTON ST 20877				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter/Foreman				12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 107 HUTTON ST 20877					
14. FATHER'S NAME FIRST MIDDLE LAST Ivor James Taylor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene E. Lewis									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213 40 6000		17. INFORMANT Germantown, Md. 20874 Jack Taylor 12703 Sesame Seed Ct.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND CHEST DUE TO, OR AS A CONSEQUENCE OF (b) DEPRESSION DUE TO, OR AS A CONSEQUENCE OF (c) MARITAL PROBLEMS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEF INDEF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 A													
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1750 P.M. 9 9 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) SHOT HIMSELF IN CHEST							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 107 HUTTON ST GAITHERSBURG MONT MD							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Francis C. May Jr.						TITLE (SPECIFY) DEPT				DATE SIGNED 9/9/86			
EXAMINER'S NAME (TYPE OR PRINT) Francis C May Jr						ADDRESS 8200 Wisconsin Ave Bethesda							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/12/86		23c. NAME OF CEMETERY OR CREMATORY Patton's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Carter County, Johnson City, Tenn.			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR SEP 17 1986		25b. REGISTRAR'S SIGNATURE [Signature]					
1331 Rockville Pike, Rockville, Md. 20852													



0-17775

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Eric A. Tietz			2a. DATE OF DEATH MONTH DAY YEAR 9/4/86			2b. HOUR 4:05P M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5/3/12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technical Info Specialist		12b. KIND OF BUSINESS OR INDUSTRY Commerce	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST August H. Tietz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minna Koch		13e. STREET ADDRESS / ZIP CODE 4612 West Virginia Avenue 20814					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Son) ADDRESS 401 E. Jefferson Gilbert E. Tietz, St, Rockville, MD					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis		5 years	
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension		5 years	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Prostate hypertrophy**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 2 19 84 , to Sept 5 19 86 , that (I) (we) last saw the deceased alive on July 29 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Joseph P. Kenrick				DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 9/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. JOSEPH P. KENRICK				22e. ADDRESS 6450 Wisconsin Ave Bethesda Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE September 8, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes				25a. DATE REC'D. BY REGISTRAR SEP 11 1986			
P.A. 7557 Wisconsin Ave., Bethesda, MD				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Fordell</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be placed in the envelope within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked as item 18 above any injury or other traumatic event, the medical examiner must be notified immediately.

00-15512

0-17791

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANNIE ELIZABETH THOMPSON			2a. DATE OF DEATH MONTH DAY YEAR SEPT 11, 1986		2b. HOUR 4:55 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 5 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10110 N.H. Ave., 20903
14. FATHER'S NAME FIRST MIDDLE LAST Frederick A. Poore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie I. Meyers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A	17. INFORMANT James M. Thompson, Sr.-(husband)-Same as 13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

GASTRIC CARCINOMA

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 mos

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

GANGRENE LEG (RIGHT)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from 9/11/86 to 9/11/86, that (I) (we) lost saw the deceased alive on 9/11/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated view the body after death.		22b. SIGNATURE Robert Lindeman MD	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Lindeman, MD		22e. ADDRESS 10215 Fernwood Rd., Bethesda, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-15-1986	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Maryland
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.	25a. DATE REC'D. BY REGISTRAR SEP 15 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified at once.

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NOTION 2005

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John LaMar Thompson			2a. DATE OF DEATH MONTH DAY YEAR September 7, 1986		2b. HOUR 7:05 P.M.			
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 11, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Vets. Admin.	
13a. STATE MD				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		
14. FATHER'S NAME FIRST MIDDLE LAST Charles F. Thompson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisie Fleming				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Etta S. Thompson, Same address as #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial INFARCT DUE TO, OR AS A CONSEQUENCE OF (c) CARDIAC ARRHYTHMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Renal failure - PROSTATIC Hypertrophy								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1984 5-26 19 1986 to 8-16 19 86 , that (I) (we) last saw the deceased alive on 8-16 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Irene G. Tamagna M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/8/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Irene G. Tamagna, MD				22e. ADDRESS 7101 Connecticut Ave., Chevy Chase, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/10/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md		
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR SEP 15 1986				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-19118

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Reutlinger Tolley			2a. DATE OF DEATH MONTH DAY YEAR Sept. 23, 1986		2b. HOUR 12:27PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5301 Westbard Circle		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE MD		13b. COUNTY Mont.	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roland Reed Reutlinger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Shively Seeger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-48-4034		17. INFORMANT ADDRESS Nancy T. Gray 5109 Baltan Rd. Beth., MD 20816	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Head & Neck Ca DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 19 86 to Sept 19 86 , that (I) (we) last saw the deceased alive on Sept 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frederick P. Smith		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-23-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick P. Smith		22e. ADDRESS 5401 Western Ave., NW, Washington, D.C. 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/25/86		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Wash., DC					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 WI Ave. NW 20016 ADDRESS				25a. DATE REC'D. BY REGISTRAR SEP 26 1986 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-17805

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
TRACY		MAE TOMAN		9 7 86		10:35 P.M.	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
FEMALE	White	5 4 96		90 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA				Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Wheaton.	University Convalescent Nsg. Home			Housewife		home	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Montgomery		Wheaton	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Edward Moore				Unknown Rankin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
No		229-14-6341		James E. Toman same as 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Carcinoma of Breast with metastases							1 yr.
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5/2/85 to 9/7/86; that (1) (we) last saw the deceased alive on 9/7/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (not) see the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED	
Myron L. Lenkin						9/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Myron L. Lenkin		2309 Shorefield Road Wheaton, Md. 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9/11/86		Gate of Heaven Cemetery		Silver Spring, Maryland	
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852				SEP 15 1986		John L. ...	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained with the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

10-17802



00-18920

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Samuel Alexander Towne			2a. DATE OF DEATH MONTH DAY YEAR September 13, 1986			2b. HOUR 9:00p M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 9, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Keene, N.H.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4004-Manor Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cost accountant		12b. KIND OF BUSINESS OR INDUSTRY I.C.C.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4004-Manor Road 20815	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Eber Towne					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Almira Sheldon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 701-05-0030		17. INFORMANT ADDRESS Verna S. Towne (Wife) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Coronary artery disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 41, to _____, Sept. 13, 19 86, that (I) (we) last saw the deceased alive on _____, Sept. Aug. 29, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William H. Silverman				DEGREE MD				22c. DATE SIGNED 9-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. SILVERMAN				22e. ADDRESS 6111 EXECUTIVE BLVD, ROCKVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-14-1986		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, District of Columbia			
24. FUNERAL DIRECTOR NAME J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002				25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE Julia Friedman-Pedraza			

05001-00



0-19018

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Glen R. Treanor			2a DATE OF DEATH MONTH DAY YEAR 09/20/86			2b HOUR 9:40am					
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Economist-Advisor		12b KIND OF BUSINESS OR INDUSTRY Internal Revenue Service			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 5526 Greystone Street / 20815		
14 FATHER'S NAME FIRST MIDDLE LAST Omri E. Treanor				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Cornelia Taylor							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW I			16b SOCIAL SECURITY NO. 216-44-4213		17 INFORMANT ADDRESS 3003 Van Ness St., #S-720 DeMarie M. Lawrence, Washington, DC 20008						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hepatorenal syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>non-A non-B hepatitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple transfusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 18</u> , 19 <u>86</u> , to <u>Sept 20</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Barbara Blaylock						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 9/21/86		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Blaylock, M.D.						22e ADDRESS 6111 Executive Blvd, Rockville, Md. 20852					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 9-22-86		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24 FUNERAL DIRECTOR NAME Richard Rapp, Inc. 1804 T Street, NW, Washington, DC 20009						25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE SEP 23 1986					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

0-12018

BRITISH

NO. 1

1941

1

00-19367

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) AGNES R. TUCKER			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 16 1986			2b. HOUR 4:48 PM		
3. SEX F	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 05 06	6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 16 1986		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp of Silver Spring				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Hotel
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10601 Inwood Avenue 20902
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Morrissey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Langan			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 577-05-4718			17. INFORMANT Son John S. Tucker			ADDRESS 8500 Utah Ave. N.W. Washington, D.C. 20015		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) arteriosclerotic cardiovascular disease years DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None								
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Paul A. DeVore, MD		TITLE (SPECIFY) Deputy Medical Examiner		DATE SIGNED 9/16/86		ADDRESS 4203 Queensbury Road Hyattsville MD 20781		
EXAMINER'S NAME (TYPE OR PRINT) Paul A. DeVore, MD		ADDRESS 500 University Blvd., W. Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep. 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



Source
Francis J. Collins, Jr.
200 University Blvd., Silver Spring, Md.
20910-1000

John S. Tucker
200 University Blvd., Silver Spring, Md.
20910-1000

Francis J. Collins, Jr.
200 University Blvd., Silver Spring, Md.
20910-1000

Francis J. Collins, Jr.
200 University Blvd., Silver Spring, Md.
20910-1000

00-19669

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the funeral transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT DOUGLAS TUCKER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 26, 1986		2b. HOUR 5:25 a.m.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 20, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IDAHO	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILL MANAGER	12b. KIND OF BUSINESS OR INDUSTRY MILL	
13a. STATE OREGON		13b. CITY OR TOWN OAKLAND	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE ROUTE 1, BOX 58A (97462)	
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST P TUCKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORIS M. LUCINGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 544-36-4194	17. INFORMANT ADDRESS MRS. IREDA TUCKER, WIFE (SAME)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE LYMPHOBLASTIC LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c) SYSTEMIC MASTOCYTOSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 2, 1986 to SEPTEMBER 26, 1986 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPTEMBER 26, 1986 , and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dean J. Metcalfe</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/26/86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DEAN J. METCALFE		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-27-1986	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.			ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR SEP 27 1986
			25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 86 26543							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nancy nmn Tuminaro				2a. DATE OF DEATH MONTH DAY YEAR Sept. 8, 1986				2b. HOUR 4:15 a.m.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Dominic Fragoneri				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rose Gatto					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 54 7422		17 INFORMANT ADDRESS Rose T. Hailey same as 13c					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse - DUE TO, OR AS A CONSEQUENCE OF (b) cardiac anky Humias in A5HD - DUE TO, OR AS A CONSEQUENCE OF (c) recurrent aspiration pneumonia 3429 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) paresis Right hemiface - trigeminal neuralgia R side -									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1980 , 19____, to Aug 27th 86 , 19____, that (I) (we) last saw the deceased alive on August 27th 86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph M. Solinas				DEGREE MD				22c. DATE SIGNED 9/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph M. Solinas				22e. ADDRESS 9801 Georgia Ave. Silver Spring, Md. 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/11/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			
1331 Rockville Pike, Rockville, Maryland 20852									

BP

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TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86-26544

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF DEATH		2d. HOUR	
SCOTT B. VAILL		9 21 1986		1:47 A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Male	Caucasian	AUG 15, 1967	19 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Rhode Island	USA	NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Kensington	Rt. 495 e. of Connecticut Ave.		Rep. Customer Service.		MDDS
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Fr. George's	Bowie	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13106 Overbrook Lane 20715	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Brian F. Vaill		Linda A. Perreault			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		219-08-2678		Brian F. Vaill	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple injuries					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		1:45 PM 9-21-1986		Passenger of auto/parked truck collision.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		road		Rt. 495 e. of Connecticut Ave., Montgomery, MD	
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Dennis F. Smyth, M.D.		M.D. Assistant MEDICAL EXAMINER		9-21-86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Dennis F. Smyth, M.D.		111 Penn St., Balto., MD		21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		SEPT 22, 1986		Metropolitan Crematory Alexandria, Fairfax, Virginia	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Beall Funeral Home		SEP 29 1986			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY OTHER INFORMATION IS NECESSARY, IF ANY TO THE MEDICAL DIRECTOR, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. SET IN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE SET IN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Jacob Van Geyten					2a. DATE OF DEATH MONTH DAY YEAR September 15, 1986			2b. HOUR A M 4:45		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Holland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
11. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3901 Joliet Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman		12b. KIND OF BUSINESS OR INDUSTRY Sears		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3901 Joliet Street / 20906					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdalena DeKoker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 104-10-6536		17. INFORMANT Marie Van Geyten, Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of the bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Arteriosclerotic heart disease, hypertension</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1985 to September 15, 1986, that (I/we) last saw the deceased alive on 9/15/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE H. Robert Birschbach, M.D.					22c. DATE SIGNED 9-15-86			22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Robert Birschbach, M.D.		
22e. ADDRESS 6320 Democracy Blvd. Bethesda, MD 20817					22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-17-86		23c. NAME OF CEMETERY OR CREMATORY Meadow Lawn Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE New Port Richey, Florida		23e. DATE REC'D. BY REGISTRAR		
24. FUNERAL DIRECTOR Richard Rapp, Inc. NAME ADDRESS 1804 T Street, NW, Washington, DC 20009					25a. REGISTRAR'S SIGNATURE SEP 17 1986					

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00-17497

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Cleared by: Dr. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNE M. VAN VRANKEN			2a. DATE OF DEATH MONTH 9 DAY 7 YEAR 86		2b. HOUR 0027 M
3. SEX female	4. RACE White	5. DATE OF BIRTH MONTH 6 DAY 27 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH SS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Nurse	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST James MIDDLE R. LAST Muse			15. MOTHER'S MAIDEN NAME FIRST Nellie MIDDLE Walker LAST Walker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT Barbara V.V. Wyatt (daughter) ADDRESS 12419 Conn. Ave., Silver Spr. Md. 20906	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one hour
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ATHEROSCLEROSIS		years
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) PREVIOUS MASSIVE MYOCARDIAL INFARCTION			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from Jan 18, 1985 to Sept 7, 1986 , that (b) (we) lost saw the deceased alive on Aug 13, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did not) view the body after death.			
22b. SIGNATURE Martin C. Shargel		DEGREE M.D.	22c. DATE SIGNED 9/7/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL		22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD - 20895	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-10-1986	23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery	23d. LOCATION CITY OR TOWN Pittsylvania STATE Virginia
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		25a. DATE REC'D. BY REGISTRAR SEP 9 1986 REGISTRAR'S SIGNATURE Julia Borden-Rodell	

00-19868

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 5 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert M Verdin, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 9/27/86		2b. HOUR 4:30 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR September 9, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Taboma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asbestos Worker		12b. KIND OF BUSINESS OR INDUSTRY Local 24
13a. STATE Maryland		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert M. Verdin, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna V. Stroman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-40-9979		17. INFORMANT ADDRESS Katherine I. Verdin Wife Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MALIGNANT MESOTHELIOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I, this hospital) attended the deceased from <u>15 MAR 86</u> , to <u>27 SEP 86</u> , that (I (we) lost saw the deceased alive on <u>26 SEP 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I (we) did) (did not) see the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Brusniak		DEGREE MD		22c. DATE SIGNED 9/27/86	
22d. ADDRESS 7525 Greenway Cir Dr. Greenbelt Md 20770		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep. 30, 1986		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland		24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md.			
25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in by the funeral director), page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 leaves any injury, or other traumatic event, the medical examiner must be notified at once.

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0-18465

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 3 4 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cathryn R. Vess			2a. DATE OF DEATH MONTH DAY YEAR 9-17-86		2b. HOUR 2:20 AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Washington DC		13c. CITY OR TOWN Washington DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Courtts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (O OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 03 2360	
17. INFORMANT Son		ADDRESS 9605 Carriage Road Kensington, MD 20895		18. CLAUDE R. VESS			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Aortic & Mitral Stenosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Congestive Heart Failure - Diabetes Mellitus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1970 to Sept 17, 1986 , that (I) (we) last saw the deceased alive on 9-17-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Peter P. Andrews M.D.				DEGREE MD		22c. DATE SIGNED 9-17-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER P. ANDREWS				22e. ADDRESS 4977 BATTERY LA BETHESDA MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 18, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., 7557 Wisconsin Ave. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 3 and 4 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.



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0-19673

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26549

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		FIRST LUCILLE		MIDDLE Jeanette		LAST VESTERMARK		7a. DATE KNOWN OF DEATH MONTH DAY YEAR		7b. HOUR	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		8. YRS.		9. DATE PRONOUNCED DEAD MONTH DAY YEAR		10. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8615 Irvington Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Educator		12b. KIND OF BUSINESS OR INDUSTRY Public Schools							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8615 Irvington Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Bartlett Allen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Burbeck											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-38-6232		17. INFORMANT Seymour D. Vestermark, Jr. same as		ADDRESS #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neck injury DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? (HEAD & CHEST)									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:20am 9-24-86				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell down steps					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) basement				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8615 Irvington St. Bethesda, Maryland					
22a. I certify that I took charge of the remains and that a full and complete autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 9-24-86	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 1 1986		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR OCT 01 1986				25b. REGISTRAR'S SIGNATURE					
7557 Wisconsin Ave. Bethesda, MD 20814 PA													

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00-18193

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anna Vince		2a. DATE OF DEATH MONTH 9 DAY 13 YEAR 86		2b. HOUR 5:53 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 9 DAY 08 YEAR 1901	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST John MIDDLE Ribnicky LAST Anna		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Potosky LAST Potosky		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 163-50-4831		17. INFORMANT Son John J. Vince 3504 Leland Street Chevy Chase, Maryland 20815

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ANOXIA DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINS. 30 MINS. 2 WEEKS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Gastritis, hemorrhage, perforated gastric ulcer**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUG 29 , 19 86 , to SEPT 13 , 19 86 , that (I) (we) last saw the deceased alive on Sept. 13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.			

21. SIGNATURE Joseph D. Connerly, MD	DEGREE M.D.	22c. DATE SIGNED Sept. 14, 1986
22a. ADDRESS 9420 Old Georgetown Rd Bethesda		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 17, 1986	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION CITY OR TOWN Pittsburgh COUNTY Pennsylvania STATE
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes P.A. 7557 Wisconsin Ave. Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR SEP 16 1986	25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

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00-17968

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 5 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas N. Wakin			2a. DATE OF DEATH MONTH DAY YEAR 9-6-86			2b. HOUR 445 A					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-29-31		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) economist		12b. KIND OF BUSINESS OR INDUSTRY Labor Dept.			
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9909 Blundon Drive #201 20902		
14. FATHER'S NAME FIRST MIDDLE LAST Tom Wakin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Aziz			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes Korean				16b. SOCIAL SECURITY NO. 124-24-1945	
17. INFORMANT ADDRESS 9909 Blundon Dr.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver metastases DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of the Colon DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 1 1/2 yr.			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Dec 24, 1985, to 9/6, 1986, that (I) (we) last saw the deceased alive on 9/5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 9/6/86	
22b. SIGNATURE Hubert J. Alpert			DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 8630 FENTON ST SILVER SPRING, MD 20910			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert J. Alpert, M.D.			22f. ADDRESS 8630 FENTON ST SILVER SPRING, MD 20910			22g. DATE REC'D. BY REGISTRAR EP 15 1986			22h. REGISTRAR'S SIGNATURE John Anderson		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 8, 86		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.		23e. DATE REC'D. BY REGISTRAR EP 15 1986		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md. 20908										25. DATE REC'D. BY REGISTRAR EP 15 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

00-17889



00-18076

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) EDNA MAE WALKER						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 30 1986		2b. HOUR A			
3. SEX F		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 10 4 15 70		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 30 1986	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BARNESVILLE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17610 CONOY RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE PA				13b. COUNTY ERIE		13c. CITY OR TOWN ERIE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 431 GARLOCK DR 99899	
14. FATHER'S NAME FIRST MIDDLE LAST John Engels						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HAYNES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 200-28-0598		17. INFORMANT Chuck Walker		ADDRESS BARNESVILLE Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) INDET Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). HYPERTENSIVE CARDIOVASCULAR DISEASE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR A P.M. 8 30 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND DEAD IN BED			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) BED				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 17610 CONOY DR BARNESVILLE MONTG MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francis C Mayle				M.D. (SPECIFY) Dep't				MEDICAL EXAMINER		DATE SIGNED 8/30/86	
EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle				ADDRESS 8200 Wagonwheel Run Bethesda MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY Erie Co Memorial Garden			
23d. LOCATION CITY OR TOWN COUNTY STATE Summit Township Erie PA				23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE SEP 05			
24. FUNERAL DIRECTOR NAME ADDRESS McHitt Barnesville Md. 20838				25. REGISTRAR'S SIGNATURE John Tindem Rader							

BP
DHMM - 17
(VR A15 ME (5))

100% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.



00-19077

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELMER CHARLES WARD, JR			2a. DATE OF DEATH MONTH DAY YEAR September 19, 1986			2b. HOUR 1:30 PM				
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 7 1907		6 AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH BARNESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 22401 OLD HUNDRED ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY MONTG		13c. CITY OR TOWN BARKER SON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 23810 OLD HUNDRED RD 20753	
14 FATHER'S NAME FIRST MIDDLE LAST SILAS WARD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSIE MORRINE STAR			ADDRESS 22401 OLD HUNDRED RD BARNESVILLE, MD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-03-4951		17 INFORMANT CHARLES WARD					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Carcinoma - Liver

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Primary Carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 1986 , 19____, to Sept 19 , 19 86 that (I) (we) last saw the deceased alive on Sept 19 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. F. Meador, Jr.				DEGREE MD		22c. DATE SIGNED Sept 19, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GRCIN F. MEADOR, JR MD				22e. ADDRESS 870 TOLL HOUSE AVE FREDERICK, MD 21701			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-22-1986		23c. NAME OF CEMETERY OR CREMATORY MONOCACY		23d. LOCATION CITY OR TOWN COUNTY STATE BEALLSVILLE MONTG MD	
24 FUNERAL DIRECTOR NAME W.C. HILTON				25a. DATE REC'D. BY REGISTRAR SEP 25 1986			
25b. REGISTRAR'S SIGNATURE [Signature]							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-18209

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 5 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MABLE G. WARFIELD			2a. DATE OF DEATH MONTH DAY YEAR September 15, 1986		2b. HOUR 8 ³⁵ AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 3 1896		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS (LAST BIRTHDAY)) 90 YRS.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10705 Glenwild Rd. 20901		12b. KIND OF BUSINESS OR INDUSTRY housewife		
14. FATHER'S NAME FIRST MIDDLE LAST James		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Blake		17. INFORMANT ADDRESS Mary E. McNall same as #13		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-0004				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from March 15, 1963, to Sept. 15, 1986, that (I) (we) lost saw the deceased alive on Sept. 12, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
21b. SIGNATURE Bennet A. Porter, Jr., M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept. 15, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bennet A. Porter, Jr., M.D.		22e. ADDRESS 9301 Coleridge Rd., Silver Spring, Md. 20901				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 18, 86		23c. NAME OF CEMETERY OR CREMATORY Parklawn		
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.		24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR SEP 18 1986		
25b. REGISTRAR'S SIGNATURE [Signature]		500 University Blvd. West, Silver Spring, Md. 20901				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

90501-3

CHIEF

EDWARD

888 8 1 933

00-19584

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST MARTIN Anthony WASKIEWICZ			MONTH DAY YEAR 9-23-86			12:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Caucasian		MONTH DAY YEAR Aug. 12, 1950		36 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, DC		United States				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Gaithersburg		17116 Queen Victoria Court				Dispatcher		Delivery Service	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17116 Queen Victoria Court 20877	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST Stanley Chester Waskiewicz				FIRST MIDDLE LAST Margaret Schwanz				17. INFORMANT ADDRESS 8225 Cambourne Ct Gaithersburg, MD 20877	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) RENAL FAILURE				3 yr.					
DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES Mellitus				20 yr.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			HOUR A.M. MONTH DAY YEAR P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 84 , to Sept 23 19 86 , that (I) (we) last saw the deceased alive on Sept 19 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<i>Stephen Hoffman</i>								9/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
Stephen Hoffman						6746 MONTROSE RD Rockville MD 20852			
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
15. Burial			Sept. 26, 1986		Gate of Heaven Cem.		CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey						SEP 29 1986		<i>Julia Davidson</i>	
300 West Montgomery Ave. Rockville, MD PA									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Removal," the medical examiner should be notified at once.

00-18318

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Henry MIDDLE A. LAST Wassmann <i>Henry A. Wassmann</i>			2a. DATE OF DEATH MONTH DAY YEAR 9-14-86		2b. HOUR 17 10 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1893		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.		7b. CITIZEN OF WHAT COUNTRY? U A A		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE 12b. COUNTY 12c. CITY OR TOWN Maryland P. G. Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2109 Charleston Place, 20783		
14. FATHER'S NAME FIRST Henry MIDDLE Wassmann LAST Wassmann			15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE Nau LAST Nau			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-48-6143		17. INFORMANT ADDRESS Paul A. Wassmann-Same as items #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis of brain stem (Stroke)</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis due to</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Age (hypoxia, and fibrillation)</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>months</i> <i>years -</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION <i>NA</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <i>NA</i>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <i>9.8</i> 19 <i>86</i> to <i>9.14</i> 19 <i>86</i> , that (I) (was) last saw the deceased alive on <i>9.14</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.						
22b. SIGNATURE <i>Rebecca L. Brennwald MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9.15.86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F.W. BRENNWALD</i>		22e. ADDRESS <i>831 University Blvd E. Silver Spring</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE 9/17/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G.Co., Md.		24. FUNERAL DIRECTOR <i>Takoma Funeral Home, Inc.</i> 254 Carroll St. N. W. D.				
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>SEP 17 1986</i>				

Henry	Hannemann	Katharine	Helen
I. H. H. H.	I. H. H. H.	I. H. H. H.	I. H. H. H.
I. H. H. H.	I. H. H. H.	I. H. H. H.	I. H. H. H.
I. H. H. H.	I. H. H. H.	I. H. H. H.	I. H. H. H.
I. H. H. H.	I. H. H. H.	I. H. H. H.	I. H. H. H.
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259 17 000

00-19549

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certification papers, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's assistant should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEORA L. WATTS					2a. DATE OF DEATH MONTH DAY YEAR 09 29 86					2b. HOUR 0530 AM
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 19 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Hyatts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5407 38th Avenue 20781		
14. FATHER'S NAME FIRST MIDDLE LAST William E Elliott					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Insley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 578 10 3088		17. INFORMANT ADDRESS Charles D. Watts, Sr. (Husband) Same as 13E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Hypertension, Diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9-28-86 to 9-29-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (If not, I did not view the body after death.)										
22b. SIGNATURE John Kijak, Jr. MD					DEGREE MD		22c. DATE SIGNED 9-29-86		22d. ADDRESS 344 University Blvd. S.S. Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/2/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland				
24. FUNERAL DIRECTOR Hines/Rinaldi				11800 New Hampshire Ave Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE		

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[Faint handwritten text at the bottom of the page, including what appears to be a signature and date.]

00-17944

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 shall be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "18 shows only injury, all other traumatic events, the medical examiner must be notified at once."

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (NAME OR PRINT) DAVID THOMAS WEIGER			2a. DATE OF DEATH MONTH DAY YEAR September 9, 1986			2b. HOUR 4AM			
2. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 1, 1944		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS		7. UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3820 Tynewick Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Montgomery Cty.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3820 Tynewick Drive 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Weiger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Davis			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 217-42-2209			17. INFORMANT Nephew			ADDRESS 15801 Crabbs Branch Way Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) A105 DUE TO, OR AS A CONSEQUENCE OF (c) Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/25/86 19 86 , to 9/9/86 19 86 , that (I) (we) lost saw the deceased alive on 8/25/86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joel Schulman			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/9/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schulman			22e. ADDRESS 9410 Old Georgetown Rd Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sep. 11, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR SEP 15 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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0-18719

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 must be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SHARON MARIE WELLS			2a. DATE OF DEATH MONTH 9 DAY 18 YEAR 86			2b. HOUR 0823M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH June DAY 19 YEAR 1954		6. AGE (IN YEARS LAST BIRTHDAY) 32		7. IF UNDER 1 YEAR MONTHS YRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Giant Food		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 46 Orchard Dr. 20878	
14. FATHER'S NAME FIRST Alby MIDDLE Embrey LAST Embrey					15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE Mills LAST Mills					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-66-1852		17. INFORMANT ADDRESS David A. Wells same as 13e					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF ADULT RESPIRATORY DISTRESS SYNDROME Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Right lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **(c)**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 16 , 19 86 , to SEPT 18 , 19 86 , that (I) (we) last saw the deceased alive on SEPT 17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.							
22b. SIGNATURE L. Martyles				DEGREE M.D.		22c. DATE SIGNED Sept 18 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. MARTYRES				22e. ADDRESS 50 W. EDMONSTON DRIVE, SUITE 208 ROCKVILLE MD 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/22/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN Rockville COUNTY Maryland STATE	

24. FUNERAL DIRECTOR **Tyson Wheeler Funeral Home, Inc.**
1331 Rockville Pike, Rockville, Maryland 2085225a. DATE REC'D. BY REGISTRAR **SEP 22 1986**
25b. REGISTRAR'S SIGNATURE **Jana Davidson-Ross**

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. FOR
STATE
REGISTRAR **Samuel B. Wendel**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Samuel B. Wendel			2a. DATE OF DEATH MONTH DAY YEAR 08 20 86			2b. HOUR 4551^P				
3. SEX male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Jan. 20, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurant Owner		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6121 Montrose Road 20852	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Wendel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blossom Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 068-10-9097		17. INFORMANT Mr. Edward Wendel 840 New Hampshire AV NW Washington, DC 20037					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) **cardiopulmonary Arrest**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **hypoxia**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Intestinal obstruction**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

coronary artery disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 8-19 19 86 to August 20 19 86 , that (1) (we) last saw the deceased alive on 8-20 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.							
22b. SIGNATURE Philip Schwartz		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 08-20-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHILIP G. SCHWARTZ		22e. ADDRESS 9715 Medicine Ct. # 315 Rockville, MD 20850					

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/86		23c. NAME OF CEMETERY OR CREMATORY Montefiore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. Albans, New York	
24. FUNERAL DIRECTOR Jos. Gawler Sonna 5130 WI. Av NW Wash. DC 20016				25a. DATE REC'D. BY REGISTRAR AUG 25 1986			
				25b. REGISTRAR'S SIGNATURE John A. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified true by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

00-17806

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) EILEEN M WENDRICH					2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 07, 1986			2b. HOUR 6:16AM	
3 SEX FEMALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR JUNE 07, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. UNDER 1 YEAR MONTHS DAYS 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10 CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5124 Russett Rd. 20853	
14. FATHER'S NAME FIRST MIDDLE LAST Edward William McSheen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Agnes St Dennis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. 138-09-4714		17 INFORMANT Brian Wendrich (son)				ADDRESS 4112 Southend Rd. Rockville, Md. 20853			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Shock DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic adenocarcinoma, cirrhosis Approximate interval between onset and death 5 min. 6 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Metastatic adenocarcinoma, cirrhosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from 9/5 , 19 86 , to 9/7 , 19 86 , that (I) viewed saw the deceased alive on 9/6 , 19 86 , and that in (my) own own opinion death occurred on the date and hour and from the causes stated above, (I) am am did not did not view the body after death.									
22b. SIGNATURE Jules R. Lodish		DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/7/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULES R. LODISH MD		22e. ADDRESS 2901 OLNEY-SANDY SPRING RD, OLNEY, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/11/86		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE [Signature]			
1331 Rockville Pike Rockville, Md. 20852									

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00-18540STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH WERHEIM			2a. DATE OF DEATH MONTH DAY YEAR 9 8 86			2b. HOUR 1:20pm								
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APR. 5, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS. HOURS MIN.		
9a. BIRTHPLACE STATE OR FOREIGN COUNTRY new york		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.								
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. TREASURY			12b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.				13b. COUNTY NONE		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4545-CONNECTICUT AVE., NW 20008				
14. FATHER'S NAME FIRST MIDDLE LAST KARL -- WERHEIM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA MARIE JANNICK												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-42-9700		17. INFORMANT ADDRESS REV. DR. REICHARD- N.L.H.-ROCKVILLE										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Alzheimer's Disease</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 16</u> , 19 <u>80</u> , to <u>Sept. 8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept. 8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22a. SIGNATURE <u>Harold F. McCann</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9-9-86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HAROLD F. MCCANN</u>			22e. ADDRESS <u>4362-26th St. N. Arlington, Va. 22207</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT. 10/86			23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.					
24. FUNERAL DIRECTOR NAME ADDRESS HYSONG CO., INC-1300 N ST., NW WASH., DC			25a. DATE REC'D. BY REGISTRAR SEP 17 1986			25b. REGISTRAR'S SIGNATURE <u>Julia Seiden-Randall</u>								

DHWH - 16-60M 7/84
(VRA 15, 4)

00-18240

NOTICE
TO THE
PUBLIC



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-19861

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 5 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eleanor B Werner			2a. DATE OF DEATH MONTH DAY YEAR 9-28-86			2b. HOUR 6:00 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-04-20		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Veterans Admin.		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6410 Stoneham Rd., / 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Henning Carlsson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda Vaberfeldt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 468 01 3894		17. INFORMANT ADDRESS Carney S. Werner, see #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aneurysmal Atherosclerosis (c) Arteriosclerotic disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Pancreatic 20 to 25% atelectasis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 12, 1986, to Sept 28, 1986, that (I) (we) lost saw the deceased alive on Sept 28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Phyllis Brandchaft			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept 29, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Brandchaft			22e. ADDRESS 10500 Summit Ave Baltimore, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 2, 1986		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS 7557 Wisconsin Av., Bethesda, Md. 20814					25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE			

BP _____

18391-0

00-20024

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		IN	
Blanche		White						Sept 30 1986		19		30		1986		MD	
2. SEX	3. RACE	4. DATE OF BIRTH		5. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		6. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
F	W	Sept 2 16 70		70 YRS.						Sept 30 1986		19		30		1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Tennessee		U.S.A.				Montgomery MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
S. L. Spg		Appl Coleroville Rd Apt 624		Fed. Fed. Gov't.		Fed. Gov't.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
MD		Monte Vista		S. L. Spg		YES <input type="checkbox"/> NO <input type="checkbox"/>		3511 Coleroville Rd Apt 624									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Robert		C.		White		Mary		Lucinda		Cain							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		410-09-8963		Edna Marion		3511 Terrier Lane Louisville, Kentucky											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } (b) <u>Chronic Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Yru</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10: <u>None</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
None																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED									
John S. Rogers		Dcp						Sept 30 1986									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John S. Rogers		1919 Seminary Rd. Silver Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		10/6/86		Monte Vista Cemetery		Johnson City				Tennessee							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
George P. Kalas		6160 Oxon Hill Rd. Furnal Home Oxon Hill, Md.		OCT 06 1986		John S. Rogers											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT.
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

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DHMH - 17
(VR A15 ME (5))

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00-18191

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000-PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha Clark Wilkinson										2a. DATE KNOWN OF DEATH ESTIMATED Sept 12 1986 4:45 PM	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH (MONTH DAY YEAR) Oct. 25, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD Sept. 12, 86 4:45 PM	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3608 Sandy Court			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse			12b. KIND OF BUSINESS OR INDUSTRY Nursing			
13a. STATE Maryland										13b. CITY OR TOWN Montgomery	
13c. CITY OR TOWN Kensington										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3608 Sandy Court/20895											
14. FATHER'S NAME FIRST MIDDLE LAST Tobe Clark					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Gardner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II					16b. SOCIAL SECURITY NO. 224-52-2162					17. INFORMANT ADDRESS Thomas P. Wilkinson Arlington, VA. 22202	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) CARCINOMATOSIS (GENERALIZED) DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA BREAST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEF 5 Yr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 49 PM 9 12 1986				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 49 PM 9 12 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) DIED IN BED			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION CITY OR TOWN COUNTY STATE 3608 Sandy Court Kensington Montgomery MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Francis C. Mayle</i>						TITLE (SPECIFY) Deputy			DATE SIGNED 9/12/86		
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle, M.D.						ADDRESS 8200 Wisconsin Avenue Bethesda, Maryland 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation				23b. DATE Sept. 14, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, PA 300 W. Montgomery Av., Rockville, Md.						25a. DATE REC'D. BY REGISTRAR SEP 16 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

1918-00

1918-00

1918-00

1918-00

0-17905

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EARL A Williams			2a. DATE OF DEATH MONTH DAY YEAR Sept 11 1986			2b. HOUR 1734				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Building Service		12b. KIND OF BUSINESS OR INDUSTRY Worker Government		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12907 Parkland Drive/20853	
14. FATHER'S NAME FIRST MIDDLE LAST John R. Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Brock							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Josephine S. Williams, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction, CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) ① ESOPHAGEAL CARCINOMA ② CHRONIC OBSTRUCTIVE LUNG DISEASE										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 80 , to Sept. 11, 19 86 , that (I) (we) last saw the deceased alive on July 31, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jeffrey Drobis			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/11/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY DROBIS			22e. ADDRESS 10500 SUMMIT AVE KENSINGTON MD. 20895							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Laurelwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Stroudsburg, PA			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes					DATE REC'D. BY REGISTRAR SEP 15 1986		25. REGISTRAR'S SIGNATURE James Davidson			
300 West Montgomery Ave. Rockville, MD PA										

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers, sign and date, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

00-17150

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their plates must be completed. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <u>Mildred Ruth Williams</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>09 2 86</u>			2b. HOUR <u>0115 M</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>10 3 11</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN) <u>Maryland</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.					
13. CITY OR TOWN OF DEATH <u>Takoma Park</u>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Supervisor</u>			16. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <u>Maryland P.G. Hyattsville</u>		18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. STREET ADDRESS / ZIP CODE <u>3800 Hamilton Street #2 20781</u>							
20. FATHER'S NAME FIRST MIDDLE LAST <u>Edward D. Boteler</u>				21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Hattie Walker</u>							
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>				23. SOCIAL SECURITY NO. <u>577-07-0087</u>		24. INFORMANT ADDRESS <u>George F. Boteler (Brother) Same as #13</u>					
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SMALL CELL Lung CANCER, METASTATIC</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
27. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
28. DATE OF OPERATION				29. CONDITION FOR WHICH OPERATION WAS PERFORMED				30. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. LOCATION STREET CITY OR TOWN COUNTY STATE					
38. I certify that (I) (this hospital) attended the deceased from <u>8/26/86</u> to <u>9/2/86</u> , that (I) (we) lost saw the deceased alive on <u>9/1</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
39. SIGNATURE <u>Ralph V. Boccia</u>				40. DEGREE <u>MD</u>				41. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		42. DATE SIGNED <u>9/2/86</u>	
43. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ralph V. Boccia</u>				44. ADDRESS <u>14800 PHYSICIAN'S LN. ROCKVILLE. 20850</u>							
45. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		46. DATE <u>09/04/86</u>		47. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				48. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood P.G. Maryland</u>			
49. FUNERAL DIRECTOR NAME <u>Francis Gasch's Sons Funeral Home, P.A.</u>						50. DATE REC'D. BY REGISTRAR <u>SEP 4 1986</u>		51. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
52. ADDRESS <u>4739 Baltimore Avenue Hyattsville, Md. 20781.</u>											

BP

02171500



00-17871

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP _____

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Caitlin			MIDDLE Brook			LAST Wilson			2b. DATE KNOWN OF DEATH ESTI-MATED			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH			2e. HOME																				
3. SEX F			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR Feb 22-86			6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS 6 16			7. IF UNDER 1 YR.			8. IF UNDER 24 HRS.			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			11. KIND OF BUSINESS OR INDUSTRY																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Annapolis			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			11. KIND OF BUSINESS OR INDUSTRY			12. CITY OR TOWN OF DEATH Burtonsville			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4216 Red Maple Ct			14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			15. STATE			16. COUNTY			17. CITY OR TOWN			18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			19. STREET ADDRESS 4216 Red Maple Ct		
14. FATHER'S NAME FIRST MIDDLE LAST Scott Douglas Wilson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Sue Pulliam			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. —			17. INFORMANT Scott D. Wilson			18. ADDRESS Same as #13			19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple Congenital Anomalies</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>None</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
19a. DATE OF OPERATION <u>None</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on			Autopsy <input type="checkbox"/>			Inspection <input checked="" type="checkbox"/>			Inquiry <input type="checkbox"/>			and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			TITLE (SPECIFY) M.D. <u>Dr. J. J. Jones</u>			DATE SIGNED SEP 12 1986			MEDICAL EXAMINER J. J. Jones																				
23a. BURIAL INFORMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-15-86			23c. NAME OF CEMETERY OR CREMATORY Lakemont Cem.			23d. LOCATION TOWN Dardsonville			COUNTY St. George			STATE Md.			24. FUNERAL DIRECTOR NAME Hardesty Funeral Home			ADDRESS Annapolis, Md.			25. DATE REC'D. BY REGISTRAR SEP 15 1986			26. REGISTRAR'S SIGNATURE J. J. Jones														

00-15851



00-19942

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST EARL	MIDDLE C.	LAST Wilson	2a. DATE OF DEATH		MONTH 9	DAY 30	YEAR 86	2b. HOUR 0615 ^M
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Representative		12b. KIND OF BUSINESS OR INDUSTRY Labor Union				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 86 W. Deer Park Rd., #T-1		
14. FATHER'S NAME FIRST MIDDLE LAST August Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona Boehmler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Korea						
16b. SOCIAL SECURITY NO. 177-20-1968		17. INFORMANT Miss Doreen Wilson, Daughter, 9335 Weathervane Place, Gaithersburg, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gram-negative sepsis DUE TO, OR AS A CONSEQUENCE OF (c) osteomyelitis right foot										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes 20 days 20 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Chronic Renal Failure, Pseudomonas Peritonitis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from October 19, 1985, to Sept. 29, 1986, that (I) (we) last saw the deceased alive on Sept. 29, 1986, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)										
22b. SIGNATURE Nelson Norris, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-30-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nelson Norris, MD		22e. ADDRESS 14505 Physicians Lane Suite 272 Rockville, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE October 1, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey P.A., 300 W. Montgomery Ave., Rockville, MD.				25a. DATE REC'D BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE Kurt...				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove conditions on pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner may be notified.

BP

00-1991-00

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Box 111
Collins



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is not any injury, or other traumatic event, the medical examiner must be contacted.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 5 7 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jason Leon Winkler			2a. DATE OF DEATH MONTH DAY YEAR 9-10-86			2b. HOUR 6:30am	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 10 86		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2 20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None.		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leon B Winkler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lynette D. Smoot		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. None		17. INFORMANT Leon B. Winkler, Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) extreme prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 2 hr							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-10 19 86, to 9-10 19 86, that (I) (we) lost saw the deceased alive on 9-10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kenneth M Huttner		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10 Sept 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth M Huttner		22e. ADDRESS 1500 Forest Glen Road Silver Spring, MD 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-11-86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc. 1804 T St., NW, Washington, DC 20009				25a. DATE REC'D. BY REGISTRAR SEP 17 1986			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

00-17781

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 7 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES LESTER WIRTH			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 3 1986			2b. HOUR 11:20_M				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 22 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1603 E. JEFFERSON STREET 20852	
14. FATHER'S NAME FIRST MIDDLE LAST ALDUS WIRTH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA NAOMI MCFALLS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 1923-1954 216-12-9248		17. INFORMANT ADDRESS CATHERINE L. WIRTH, 1603 E. JEFFERSON STREET, APT 101, ROCKVILLE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 31 , 19 86 , to SEPTEMBER 3 , 19 86 , that (I) (we) lost saw the deceased alive on SEPTEMBER 3 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>G. A. Calleja</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3 SEP 86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. A. CALLEJA, LT. MC. USNR					22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE Sept. 6, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Anne's			23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel, Annapolis, MD					25a. DATE REC'D. BY REGISTRAR SEP 11 1986					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

Annals of the American Academy of Arts and Sciences
 Vol. 1, No. 1, 1901
 Boston, U.S.A.

477GR,
00-18028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 1 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James W. Wood			2a. DATE OF DEATH MONTH 9 DAY 4 YEAR 86			2b. HOUR 3:30 A M					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 1 DAY 1 YEAR 09		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY Montg 13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1317 Wheaton Lane / 20902					
14. FATHER'S NAME FIRST James MIDDLE Wood LAST Wood			15. MOTHER'S MAIDEN NAME FIRST Maudie MIDDLE Horn LAST Horn								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 214-01-0046			17. INFORMANT NAME Rogina Smith ADDRESS 4401 Smith Village Rd. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Anoxic encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) 1 week										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: -											
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/4 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from 8/14 , 19 86 , to 9/4 , 19 86 , that (b) (we) lost saw the deceased alive on 9/3 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE L. Paul Kretting MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/4/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Paul Kretting MD			22e. ADDRESS 2101 Med PKA Silver Spring MD 20902								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-8-86		23c. NAME OF CEMETERY OR CREMATORY Allen Chapel Cem.			23d. LOCATION CITY OR TOWN Wheaton COUNTY Montgomery STATE MD			
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. Washington Rockville, MD 20850			25a. DATE REC'D. BY REGISTRAR SEP 10 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP _____

00-19706

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 6 5 7 3	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Peterson Lillian Wood					2a. DATE OF DEATH MONTH DAY YEAR 9 29 86			2b. HOUR 10:30 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 23 19		6. AGE (IN YEARS LAST BIRTHDAY) 67 yrs		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 6 7			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Vault Works			
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14005 Bramble La. #T-2 20707			
14. FATHER'S NAME FIRST MIDDLE LAST Charles John Peterson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Otillia Euphemia Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 215-09-5380		17. INFORMANT 13501 Briarcroft Ct. Christopher Wood Laurel, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hepatic-renal failure DUE TO, OR AS A CONSEQUENCE OF (b) colon carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1h											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Sept 5 , 19 85 , to Sept 29 , 19 86 , that (I) (we) last saw the deceased alive on Sept 29 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE Martin Weltz					DEGREE MD		22c. DATE SIGNED 9/29/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin Weltz					22e. ADDRESS 7025 Overman Cir Dr Greenbelt MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/3/86		23c. NAME OF CEMETERY OR CREMATORY LoudonPk. Cemetery		23d. LOCATION Baltimore Baltimore Md.				
24. FUNERAL DIRECTOR NAME FLECK F.H. INC. 7601 SANDY SPRING RD. LAUREL MD. 20707					25a. DATE REC'D. BY REGISTRAR OCT 2 1986		25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

Continued

188

1919

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 28 shows any injury, or other traumatic event, the medical examiner should be called for an autopsy.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDWARD W. WOOP			2a. DATE OF DEATH MONTH 9 DAY 21 YEAR 86			2b. HOUR 0001 M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 12 DAY 03 YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH Rockville md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE	
12b. KIND OF BUSINESS OR INDUSTRY Building Eng.		13a. STATE md		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 301 Russell Ave 20853		14. FATHER'S NAME FIRST Fernando MIDDLE OTTO LAST WOOP		15. MOTHER'S MAIDEN NAME FIRST EDITH MIDDLE - LAST DUNN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES) US Army WWII 108-22-3054		17. INFORMANT ADDRESS 9717 LOOKOUT PLACE Dorothy JOHANNSON, Gaithersburg MD 20879			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) status epilepticus DUE TO, OR AS A CONSEQUENCE OF (c) "							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH home
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 82 to date 19 82 , that (I) (we) last saw the deceased alive on 9/20/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE John J. Ward MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Ward, 6116 Robinson Rd		22e. ADDRESS 6116 Robinson Rd Bethesda MD 20817					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-23-86		23c. NAME OF CEMETERY OR CREMATORY LEES Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.	
24. FUNERAL DIRECTOR GARTNER-SANDISON F.H. Gaithersburg MD 20878				25. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

00-19370

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth Elizabeth Wyatt			2a. DATE OF DEATH MONTH DAY YEAR September 18 1986		2b. HOUR 10:52 R.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8 8 16		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Dakota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4423 Renn Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Credit Processor		12b. KIND OF BUSINESS OR INDUSTRY Sears
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4423 Renn Street 20853	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edwin Carlson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina Elizabeth Leander		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 482-12-2340		17. INFORMANT SON ADDRESS Wayne Wyatt same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer Unknown DUE TO, OR AS A CONSEQUENCE OF Primary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 30 19 85 to Sept 19 86 , that (I) (we) last saw the deceased alive on Aug 30 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Fred Smith, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept. 19, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fred Smith, M.D.		22e. ADDRESS 5401 Western Ave. N.W., Washington, D.C. 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 22, 86		23c. NAME OF CEMETERY OR CREMATORY Parklawn	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.		25a. DATE REC'D. BY REGISTRAR SEP 25 1986			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25b. REGISTRAR'S SIGNATURE W. Anderson-Henderson			
500 University Blvd. West, Silver Spring, Md					

BP _____

0-19758

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner and the medical director must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 5 7 6	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ALEXIS LEANN YOUNG					2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 24 1986			2b. HOUR P 10:36			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 24 1986		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. 10		IF UNDER 1 YEAR MONTHS DAYS 10 8			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY PRINCE GEO'S		13c. CITY OR TOWN LANDOVER HILLS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4426 68th PLACE 20784			
14. FATHER'S NAME FIRST MIDDLE LAST CARMEN EUGENE YOUNG					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VANESSA GOLDSMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS VANESSA YOUNG, 4426 68th PLACE, #C-5,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LANDOVER HILLS, MD 20784 HYALINE MEMBRANE DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EXTREME PREMATURITY DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 24 19 86 to SEPTEMBER 24 19 86 , that (I) (we) lost saw the deceased alive on SEPTEMBER 24 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. H. Nading</i>					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 9/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. NADING, CDR, MC, USN					22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Dr. Thompson - LCDR USN			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAVAL HOSPITAL BETHESDA MD					25a. DATE REC'D. BY REGISTRAR OCT 01 1986		25b. REGISTRAR'S SIGNATURE <i>J. H. Nading</i>				

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THE
CIVIL
SERVICE

00-19593

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DARREN DAVID YUHAS										2a. DATE OF DEATH KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 21 1986		2b. HOUR M 1:47 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR AUG 16, 1967		6. AGE (IN YEARS) LAST BIRTHDAY 19 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 21 1986		2d. HOUR M 1:47 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Mexico				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Kensington				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 495 e. of Connecticut Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY Univ. of MD	
13a. STATE Maryland				13b. COUNTY Pr. George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4420 Ockford Lane 20715					
14. FATHER'S NAME FIRST MIDDLE LAST David Yuhas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Virnstein											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-06-9795				17. INFORMANT ADDRESS Mary L. Yuhas 4420 Ockford Lane Bowie, MD 20715							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:45xx 9-21- 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/parked truck collision.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 495 e. of Connecticut Ave., Montgomery, MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 9-21-86			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE SEPT 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Fairfax, Virginia					
24. FUNERAL DIRECTOR NAME Beall Funeral Home				ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043				25a. DATE REC'D. BY REGISTRAR SEP 29 1986				25b. REGISTRAR'S SIGNATURE			

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00-19595

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 5 7 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CARLA		FIRST ZIMMERMAN		LAST		2a. DATE OF DEATH MONTH 9 DAY 24 YEAR 86		2b. HOUR 2:45 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH April DAY 26 YEAR 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTEGOMERY Co., MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Hebrew Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF YEAR) Clerk Administrative		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY Montgomery		13b. CITY OR TOWN Washington, D.C.		13c. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2480 16th Street, N.W. 20009			
14. FATHER'S NAME FIRST Not Available MIDDLE Not Available LAST Not Available		15. MOTHER'S MAIDEN NAME FIRST Not Available MIDDLE Not Available LAST Not Available							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-60-5203		17. INFORMANT Hedwig E. Lee ADDRESS 2450 Virginia Ave., N.W. Washington, D.C. 20037					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS	
DUE TO, OR AS A CONSEQUENCE OF (b) —									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) —									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS - HYPERTENSION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-5-1986 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 5-5-1986 CITY OR TOWN Rockville COUNTY Montgomery STATE MD		21g. DATE OF OPERATION 9/24/86			
22a. I certify that (a) (this hospital) attended the deceased from 9/24/86 to 9/24/86 , that (b) (we) last saw the deceased alive on 9/24/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D.D. Patel		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/24/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL		22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria COUNTY Virginia STATE Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE J. K. ...					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified directly.

00-10002



00-181812

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 6 2 6 5 7 7

1. DECEASED NAME (TYPE OR PRINT) RUTH			2a. DATE OF DEATH MONTH DAY YEAR Sept. 13 1986			2b. HOUR 3:15pm				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 11 10		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 76		6. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Breslau, Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 257 Congressional Lane, #504				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist (ret)		12b. KIND OF BUSINESS OR INDUSTRY Hospital		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 257 Congressional Lane, 20852	
14. FATHER'S NAME FIRST MIDDLE LAST Max Herzberg			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Else Foerder			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 139-24-4039			17. INFORMANT ADDRESS Rockville, Md. 20852			17. INFORMANT Klaus M. Zwilsky 11422 Dorchester Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) brain metastasis, liver metastasis DUE TO, OR AS A CONSEQUENCE OF (c) breast cancer, colon cancer								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 month 10 month 5 yrs, 10 month		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Nov 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED INJURY <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT INJURY <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 106 Irving St. N.W. #44, Wash DC 20010		21g. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/13 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Bruce A. Silver MD								22c. DATE SIGNED 9/14/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE A. SILVER				22e. ADDRESS 106 Irving St. N.W. #44, Wash DC 20010						
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 9-15-86		23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lakewood New Jersey				
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Memorial Chapels				25a. DATE REC'D. BY REGISTRAR SEP 16 1986		25b. REGISTRAR'S SIGNATURE [Signature]				
1170 Rockville Pike, Rockville, Maryland 20852										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers, pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, please any injury, or other traumatic event, the medical examiner will be notified at once.

00-18135

